Application for Admission

Stress Disorder Treatment Program

Colmery-O'Neil VAMC
Stress Disorder Treatment Program (4-2C)
2200 SW Gage Boulevard
Topeka, KS 66622
telephone (785) 350-3111 ext. 52110, fax (785) 350-4624

Instructions

- Complete all parts of the application packet. Be sure to answer the specific questions asked on the application. Better information enables us to make an appropriate admission decision more quickly.
- Notice that a signature of your current mental health treater is required.
- If you are missing some of the required materials, please mail what you have. You can then mail the remaining materials when you are able. Please know that incomplete applications are held on file and not processed until all required information **(marked * below)** is received.
- Please call if there are specific questions about how to complete the application packet.

	Enclosed	To be Sent	Comment
Completed application*	_____	_____	Completed by patient and signed by referring provider
Copy of DD-214*	_____	_____	**Do not send original**
10-10EZ	_____	_____	ONLY if **NOT** enrolled in VHA healthcare
PTSD Checklist (PCL)*	_____	_____	Current PTSD symptom checklist
Medication List*	_____	_____	May use copy from doctor/pharmacy

In terms of treatment needs, please indicate your biggest priority for treatment at this time: (CHECK ONE)

- ☐ Intensive PTSD treatment
- ☐ Structured substance abuse treatment
- ☐ Vocational (career) training
- ☐ Housing assistance
- ☐ Treatment that addresses current life stressors

Note: If you are primarily interested in service-connection and do not wish to undergo treatment, we encourage you to coordinate those efforts with your local resources.

Are you currently applying to any other inpatient or residential programs? If so, please list those programs below so we can appropriately coordinate services:

_____

_____

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****TO BE COMPLETED BY THE VETERAN****

Veteran's Name:_____ Date of Application: _____

Social Security Number:_____ Date of Birth _____ Gender: _____

Mailing Address:_____

_____

Home Telephone Number:_____ Work:_____ Cell:_____

Email:_____

Ethnicity (check one):

- ☐ Asian/Pacific Islander
- ☐ African American/Black
- ☐ Hispanic/Latino American
- ☐ Caucasian
- ☐ Native American
- ☐ Mixed Ethnicity _____
- ☐ Other _____

During which era have you served? (check all that apply)

- ☐ WWII (12/7/1941-12/31/1946)
- ☐ Pre-Korean Conflict (1/1/1947-6/26/1950)
- ☐ Korean Conflict (6/27/1950-1/31/1955)
- ☐ Between Korea and Vietnam Eras (2/1/1955-2/27/1961)
- ☐ Vietnam Era (2/28/1961-5/7/1975)
- ☐ Post-Vietnam Era (5/8/1975-8/1/1990)
- ☐ Persian Gulf War (8/2/1990-9/10/2001)
- ☐ OEF/OIF/OND (9/11/2001-present)
- ☐ Other_____

Have you served in a combat zone (i.e., area for which you received combat pay)? ☐ Yes ☐ No

Were you ever a Prisoner of War (POW)? ☐ Yes ☐ No

Have you experienced a Military Sexual Trauma? ☐ Yes ☐ No

Do you have any problems with reading, writing, or hearing? ☐ Yes ☐ No If yes, please explain:

_____

_____

Have you attended this PTSD program in the past? □ Yes □ No If yes, when? _____

If you have previously attended this program, please describe your experiences in the program and why you would like to return:_____

_____

_____

_____

Goals for Treatment: What (specifically) do you want to accomplish in this program?

_____

_____

_____

_____

_____

Traumatic Event(s): The program is designed to offer a decrease in trauma-related symptoms. Please *briefly* describe the traumatic event(s) that have led to your PTSD symptoms and you would like to focus on in the program. These can be military or civilian related. In this section it is necessary that you identify some specific events that bother you and describe them in enough detail that we can tell what happened.

_____

_____

_____

_____

_____

_____

_____

_____

Other Issues: Are there other issues in your life you want to work on in this program? What are they?

_____

_____

_____

_____

Education: Highest grade completed: _____ Please check: □ Have G.E.D. □ High School Graduate

Describe any further education you have (such as technical schools or college):

_____

_____

Employment History: Current work status: □ Working □ Unemployed □ Unable to work □ Retired

What is your usual type of work? _____

Please list your current or last job_____

Date you last worked _____

If you are currently not working, please briefly describe the reason _____

_____

Are you Service Connected (circle one)? □ Yes □ No % PTSD_____ % Other_____

Are you currently pursing service connection or an increase in service connection for a mental health related disorder? If yes, please comment on how your goals related to service connection may impact your participation in our recovery oriented program.

_____

_____

_____

***The Stress Disorder Treatment Program is designed for treatment and rehabilitation. Veterans who only wish to establish a service-connected disability should pursue that through available administrative channels.**

Relationship History: Please list: all past and current marriages/partnerships (name of partner/spouse, dates/length of relationship/marriage) and current significant relationships and/or partnerships. *The Stress Disorder Treatment Program does not discriminate due to a Veteran's sexual orientation.*

_____

_____

_____

Please list all children, ages of children and describe your relationship with them.

_____

_____

Family History: Describe your "growing-up" years. Who raised you? Who lived in your household? Where were you born and raised? How many siblings did you have? What was your experience being a child in your family? Were there problems? Were you abused? Did you have disciplinary or legal problems? At what age did you leave home? Etc.

_____

_____

_____

_____

_____

_____

Military History:

*Branch of service:*_____

*Dates of active military service:*_____

At what age did you enter the service? _____ Were you drafted or did you enlist? _____

Where was basic training? _____

Where was AIT training? _____

What types of training did you have? _____

What was your MOS? _____

What was your highest rank? _____

If you served in combat, what were the dates of your active military combat service and where? _____

_____

Describe your military service. What were your duty stations, units, and job responsibilities?

_____

_____

_____

_____

Were you honorably discharged? □ Yes □ No If no, please explain: _____

_____

Did you have any legal or disciplinary problems while you were in the military? □ Yes □ No

If yes, please describe:

_____

_____

****Remember to include a copy of your DD-214 with your application. If you are Active Duty and do not have a DD-214, please let us know.**

Previous Treatment: Please list previous **inpatient or outpatient treatment** you have had for PTSD, MST or other mental health problems. **Include place, dates, reason for treatment and completion date.**

List **past** treatments:_____

_____

_____

_____

_____

List **current** treatments/groups and/or individual therapies you are participating in. Include duration and how often you attend:

_____

_____

_____

_____

If you did not complete any treatment, please give the reason for the incompletion: _____

_____

What was helpful to you in these treatment programs? _____

_____

What did you find least helpful and why?_____

_____

Substance Use/Abuse: (***Veterans participating in the program are expected to abstain from substance use during treatment.***)

When was your first use of alcohol or illicit drugs? _____

Have you had any treatment for substance use? □ Yes □ No If yes, when and where?_____

_____

_____

Do you currently use alcohol or illicit drugs at all? □ Yes □ No

When was your last use of any alcohol? _____

When was your last use of any illegal, un-prescribed, or illicit drugs? _____

_____

Have you or do you attend self-help or support groups for substance abuse, eating disorders, or other addiction problems (AA, NA, etc.)? □ Yes □ No If yes, please explain: _____

_____

Have you had problems with gambling or any other addiction problems? □ Yes □ No If yes, what are they and what have you done about them? _____

_____

_____

Legal Problems: *Suitability for treatment in the SDTP is determined on an individual basis. Decisions are made on grounds of clinical appropriateness, but may also take into consideration the likelihood that treatment will be interfered with or otherwise compromised. Veterans with current or pending legal problems will be required to furnish additional information and documentation about those. Falsifying or withholding information about legal matters is grounds for denial of an application or dismissal from the program. Resolution of pending legal issues may be required prior to admission.*

Please list and describe all PAST legal problems. What were the charges and the outcome of those? Give the dates, where these events occurred, etc.

_____

_____

_____

Please list and describe all CURRENT legal problems. What were the charges and the outcome of those? Give the dates, where these events occurred, etc.

_____

_____

_____

Are you presently on parole or probation? □ Yes □ No If yes, please list any scheduled court dates and requirements of your parole/probation:

_____

_____

Religious/Spiritual Beliefs: *(This information is to help understand and support the spiritual needs of those in treatment. The Stress Disorder Treatment Program does not discriminate due to a veteran's religious beliefs.)* Describe your religious/spiritual upbringing. Do you have a current religious preference? Are you currently active in the practice of your faith? Have your religious/ spiritual beliefs changed over the years? Describe any current spiritual concerns:

_____

_____

_____

Strengths: What are some positive qualities about you as a person? What assets do you bring to treatment? What are some of your talents or abilities?

_____

_____

_____

Medical Issues: *Please be aware that our unit is not a chronic illness or pain management program. We make every effort to address acute medical problems, but our primary focus is treatment of trauma-related mental health concerns. Medical stability is necessary prior to being accepted for treatment in this program.*

List any medical issues, including chronic pain, that would be important for us to know about:

_____

_____

_____

_____

Do you have any current health problems that will make it difficult for you to participate in programming?

□ Yes □ No If yes, please explain: _____

_____

_____

Does anyone assist you with taking medications (e.g., regularly reminds you to take medications, fills your med planner)? Yes□ No□ If yes, please identify the person(s), relationship to you, and describe the type of assistance they provide:

_____

_____

_____

If you have chronic pain, are you satisfied with your current pain management plan?
□ Not applicable □ Yes □ No, because_____

Resources and Follow-up/Aftercare Resource: With whom do you plan to do follow-up care if you are accepted and attend the program? Include contact information. Include **provider name, title, location (i.e. Vet Center, CBOC, VA hospital), and telephone number of the person(s)**

_____

_____

_____

_____

If you have questions*:* *The Admissions Coordinator for this program can be reached by phone at (785) 350-3111, extensions 52139 or 52110 from 8:00AM - 4:30PM, M-F. Topeka, KS is in the Central Time Zone.*

Return completed applications to: Kirsten Watkins Psy.D., Admissions Coordinator
at the address or fax number on the first page of this application

Messages and contacts: Is there someone who can get a message to you if we are not able to reach you at the addresses given at the beginning of this form?

_____

Name *Relationship* *Address* *Phone*

_____ _____

Veteran's signature and date *Referring therapist's signature and date*
REQUIRED

Patient Name:
_____

Last 4 Digits of SSN:
_____

Date: _____

PCL-5: MONTHLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4