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.

<table>
<thead>
<tr>
<th>Enclosed</th>
<th>To be Sent</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed application*</td>
<td>______</td>
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<tr>
<td>Copy of DD-214*</td>
<td>______</td>
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<tr>
<td>10-10EZ</td>
<td>______</td>
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<tr>
<td>PTSD Checklist (PCL)*</td>
<td>______</td>
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<td>Medication List*</td>
<td>______</td>
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</table>

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:

____________________________________________________________________________________
____________________________________________________________________________________
Application for Admission
**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 ☐ Caucasian ☐ Other ________________
☐ African American/Black ☐ Native American
☐ Hispanic/Latino American ☐ Mixed Ethnicity ________________

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

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**
**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.

<table>
<thead>
<tr>
<th>In the past month, how much were you bothered by:</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing, and unwanted memories of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Repeated, disturbing dreams of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Suddenly feeling or acting as if the stressful experience were actually happening again <em>(as if you were actually back there reliving it)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Feeling very upset when something reminded you of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Having strong physical reactions when something reminded you of the stressful experience <em>(for example, heart pounding, trouble breathing, sweating)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Avoiding memories, thoughts, or feelings related to the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Avoiding external reminders of the stressful experience <em>(for example, people, places, conversations, activities, objects, or situations)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Trouble remembering important parts of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Having strong negative beliefs about yourself, other people, or the world <em>(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)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Blaming yourself or someone else for the stressful experience or what happened after it?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Loss of interest in activities that you used to enjoy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Feeling distant or cut off from other people?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Trouble experiencing positive feelings <em>(for example, being unable to feel happiness or have loving feelings for people close to you)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Irritable behavior, angry outbursts, or acting aggressively?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Taking too many risks or doing things that could cause you harm?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Being “superalert” or watchful or on guard?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. Feeling jumpy or easily startled?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Having difficulty concentrating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Trouble falling or staying asleep?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD