

## APPLICATION FOR OLMSTED COUNTY INTENSIVE OUTPATIENT DBT PROGRAM

Today's Date:	
Name of Applicant:	DOB:
Address:	
Phone number where you can be reached:	Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Living Situation:	Gender:
Current Diagnoses:	
Current Medication:	
What is the frequency with which you take your prescribed medication? <input type="checkbox"/> All the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Other, explain if needed:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single/Never Married <input type="checkbox"/> Divorced	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Status:	If working, average hours per week in last 30 days:
Volunteering? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, average hours per week in last 30 days:
Currently enrolled in school? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, average hours per week in school in last 30 days:
Highest education level completed:	Number of arrests in last 30 days:
Do you have children under age 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what ages: Do they reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do your children have special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age you first received mental health services:
Have you received DBT services in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and for how long?	
Have you been in an IRTS residential program in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you utilized an IRTS crisis bed in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you had any medical admissions to the hospital for self-harm injuries in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you had any psychiatric hospital admissions in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you had any emergency room visits for mental health issues in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you attempted suicide in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you engaged in non-suicidal self-injury in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	

Other than those above, describe any other risky, impulsive behavior (e.g. impulsive sexual behaviors, gambling, alcohol, drugs, impulsive spending, binge eating, etc.):

Suicidal Ideation – within the past year, I have thought about killing myself:  Never  Sometimes  A lot

Please check the box if you experience difficulty in that area as a result of symptoms.

If yes, please give a brief description.

Utilizing mental health services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Use of drugs and alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Educational, vocation and daily activity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Social functioning	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Interpersonal relationships	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Self-care and independent living skills	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical or dental health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Management of finances	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Housing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Legal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (e.g. sexuality, spiritual, parenting, cultural, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Briefly describe your weekly commitments (full or part-time work, volunteer work, school, family/friend obligations, hobbies, etc.):

Briefly describe your primary concerns and the goals you would like to pursue with the help of our DBT program:

Briefly describe your current professional support network (doctors, psychiatrist, psychologist, therapist, support groups, etc.):

Please give us a sense of your schedule and availability. *Note that none of our therapists work on weekends.*

Rank when you can come to skills group training:

Monday PM Group (1-3:30 pm)

Wednesday PM Group (2:30-5:00 pm)

Tuesday AM Group (9:30-noon)

Thursday PM Group (4:00-6:00 pm)

Describe your availability to come in for individual therapy (meet once a week for an hour):

Transportation – how will you get here?

own car  bus  taxi  medical transportation/ZIPS  Other:

Do you have any parenting/childcare issues?

Will you have child care set up for your children while attending skills group and individual therapy?

Do you have health insurance?  Yes  No

If yes, what type?

Please include a copy of your insurance cards.