ROCKY MOUNTAIN BRAINSPOTTING INSTITUTE

Scholarship Treatment Fund

Note: This information is confidential and will be used for the sole purpose of tracking demographic information about the people we serve through this program.
RMBI does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, or sexual orientation, in any of its activities or operations.

Demographic Information:

Name:	Date:
Date of Birth:	Relationship Status:
Age:	Race/Ethnicity
# of Dependents:	Gender: M / F / I do not identify as M or F
Home/Mobile Phone:	Is it ok to leave a message for you at this number?Y / N
Work Phone:	Is it ok to leave a message for you at this number?Y / N
Mailing Address:	
City, State, Zip Code	
E-mail Address:	
Current Employer:	Position Title:
Disabled: Physical Mental or Both	
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
How long on this Job:	Do you enjoy your job?
Education Level:	Special Trainings:
Hobbies:	Military Background:
Talents:	
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

Physical Health Data:

Describe your Physical Health: Excellent: ____Good: ____Average____Poor_____Weight:_____Height:____

Are you now under a doctor's care? ________If yes, name of doctor________________________________

Reason for doctor's care____

Hospitalizations and

Reasons:____

____

Have you ever been hospitalized for a mental illness?____ Describe________________________________

Have you even been diagnosed with a mental illness?____

If you have been diagnosed with a mental illness what is your diagnosis or diagnoses?

____

Recent major illnesses or surgeries____

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Do you get regular exercise? Yes_____ No_______

If so, what type and how often? ____

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Sleep issues	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Seizures
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Family Data:

Birthplace: ____

FATHER: age now if living: ______Age at Death______Cause: ______________Your age then:________

MOTHER: age now if living ______Age at Death ______Cause: ______________Your age then:________

Do your parents live together? Yes ______No_______Were Parents Divorced? Yes _______No_______

Do you feel closest to your Mother ______Father _______Neither_______

Your Marital Status________#of marriages __________________Spouse's Name___________________

Living with a partner _________How long ______________Partner's Name_________________________

CHILDREN:#1 M F Age_____ #2 M F Age______ #3 M F Age______#4 M F Age____#5 M F Age_____

SIBLINGS: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age______

Family Alcoholism or Domestic Violence?________________ Sexual Addictions or Abuse?____________

Parents divorced? ___________If yes, your age at the time__________________

Any step-parents? ________If yes, describe your relationship with them_____________________________

____

If raised by someone other than your birth parents, describe:_______________________________________

____

Legal Data:

Have you ever been incarcerated (Jail or Prison)? Yes __________No_ _________Dates____________

Reason____Where_______________________________

Have you ever had a DWI (Driving While Intoxicated)? Yes ________No_______How Many:______
Have you ever had a DUI (Driving Under the Influence)? Yes________No______How Many:______
Are you currently on Probation? Yes _________No_________Explain__________________________

Religious

Current Religious Preference or Spiritual Preference if any:

____

List 3 Support Systems you have in your life right now:

1.____
2.____
3.____

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Are there any specific behaviors, actions, habits that you would like to change?

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Chemical Dependency Data:

Have you ever been in treatment for Chemical Dependency/Addiction? Yes______No______
If Yes, Where:____
Treatment was for what chemical: __________________________Are you involved in a recovery program? Yes _____No_____ Do you attend meetings? Yes ____No ____Have you completed a 12-step program? Yes ____No _____When _______Do you have a sponsor? Yes_____ No_____

Alcohol and Drug History:

Have you ever felt you should cut down on your drinking and/or drug use? Yes_____ No_____
Have people annoyed you by criticizing your drinking and/or drug use? Yes_____ No_____
Have you ever felt bad or guilty about your drinking and/or drug use? Yes_____ No_____

Have you ever used alcohol or drugs in the morning to steady your nerves or get rid of a hang-over?
Yes_____ No_____

Have you ever had any drug or alcohol related arrests? Yes_____ No_____

Have you ever had any D.T.'s? (Delirium tremens) Yes_____ No_____

Have you experienced any blackouts from drugs or alcohol? Yes_____ No_____

Have you ever injected drugs? Yes_____ No_____

Treatment History

Have you seen an individual therapist for trauma treatment before? Yes__________ No_________

If so, please describe the type of therapy and approach: ____

____

Do you have a psychiatric diagnosis? Yes________ No _______

If so, what is it and when were you diagnosed?____

____

____

How did you find out about the treatment fund?

____

____

Please specifically and clearly Identify one trauma that you would like to work on which you have not worked on before.

____

Financial Information:

Do you have insurance? Yes _______ No __________

If so, please identify the company and whether or not it covers any portion of psychotherapy.

____

Do you have access to funds to pay for therapy through Victim Compensation, vocational rehabilitation programs, disability coverage, Worker's Compensation, or auto accident insurance? Yes________ No_______

Please specify:____

Please describe your financial need for this program. ____

____

____

Please indicate your total ANNUAL household income.____

How many people are in your household?______________