Revised 11-2018

GATEWAY TO DISCOVERY

Carmen Clavin
Gateway to Discovery
PO Box 432
Fort Dodge, IA 50501
(515) 302-8162
gatewaytdhouse@gmail.com

Entrance Request

Name _____Alias: _____Date: _____
Ethnicity: _____Race: _____Age: _____
Address: _____
DOB: _____ SS#: _____Phone Number: _____
Emergency Contact: _____Phone Number: _____
Relation to Emergency Contact: _____

Referral Name: _____
Agency: _____
Phone: _____
Fax: _____
E-mail: _____

Please attach the following: most recent detailed ASAM, completed release of information, medication list and dosages, copies of the TB test results and physical, completed entrance request with all questions completed.

Treatment History:

Number of Treatments Attended: _____

If yes, when? _____ Where? _____ Level of care: _____
When? _____ Where? _____ Level of care: _____
When? _____ Where? _____ Level of care: _____
When? _____ Where? _____ Level of care: _____
Have you attended 12-step AA/NA Meetings in the past _____ Other _____
Was the treatment a positive experience? _____
_____
Longest length of Sobriety: _____

Alcohol & Drug History

What is your drug of choice? _____
Mark substances you've used in the past/ **include date of last use and method**:

Alcohol _____
Marijuana _____
Crack/ cocaine _____
Narcotics (opium, morphine, heroin) _____
Other: _____

Benzodiazepines (Zanax,Valium,Ativan)_____
Hallucinogens (LSD/acid, mushrooms) _____
Prescription Drugs _____
Other: _____
Use the space below to describe your addiction:

Opiates (oxycodone, fentanyl, methadone, suboxone, tramadol, codeine, Darvocet) _____

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Barbiturates (Amobarbital, Pentobarbital, Phenobarbital, Secobarbital, Tuinal)_____

Do you use drugs when you drink? Yes _____ No _____

Do you use drugs when you do not drink? Yes _____ No _____
Do you use drugs to improve the effects of alcohol? Yes _____ No _____
When you stop drinking or using drugs, what kind of problems do you experience?
Nervousness _____ Low energy _____ Panic _____
Suicidal thoughts _____ Depression _____ Nausea _____
Severe cravings _____ Headaches _____ Irritability _____
Hallucinations _____ Feeling weak ____ Insomnia _____
Excess appetite _____ Feeling Speedy ____ Poor Memory ____
Decreased sleep _____ Aches & Pains _____ Diarrhea _____
Increased use of other drugs _____
Does your spouse or current partner use drugs and/or alcohol? Yes _____ No _____
If yes, describe: _____
Do you have friends that use drugs and/or alcohol? Yes_____ No_____
If yes, describe: _____
At what age did you start drinking alcohol? _____
Why did you begin drinking? _____
At what age did you start using drugs? _____
Why did you begin using drugs? _____
How long have you been using your drug of choice heavily? _____
How much money do you spend on drugs/alcohol in one month? _____

Do you feel that you are addicted to alcohol or drugs? Yes _____ No _____
Please explain: _____
Have you tried to stop using before? Yes _____ No _____
What happened? _____
How has alcohol and drugs affected your life (job, health, marriage, legal, etc.)? _____
_____
_____
_____
_____
Do alcohol/drug use and sexual activities go together for you?
Always _____ Often _____ Occasionally _____ Never _____
Has your alcohol use caused a reduction in your sex drive or produced an inability to function sexually?
Yes _____ No _____
If yes, please describe: _____
Do you consider your recent sexual behavior to be compulsive? Yes _____ No _____
Which do you consider more difficult to control?
Drug use _____ Alcohol use_____ Sexual acting out _____ No difficulties _____
Is there any aspect of your sexual behavior that concerns you? Yes_____ No _____
If yes, please explain: _____

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Physical Health History and Medical

Do you have any medical insurance? _____
With who? _____ Can you provide proof of insurance? _____
Do you have any current medical problems? Yes_____ No _____
If yes, describe: _____
_____
Are you currently under the care of a physician? Yes_____ No _____
Name: _____ Phone Number: _____
Address: _____
City: _____ Zip: _____
List all doctors and medical problems they treat: _____
_____
List any prescribed medications you are currently taking: _____
_____
_____
_____
Do you take your medications compliantly? _____
If no, why? _____
Are you experiencing, or have you experienced any of the following? Mark past or present
Chest pains _____ Headaches _____ Seizures _____ Sweats _____
Loss of consciousness _____ Liver problems _____ Nausea & Vomiting _____
Are you aware of any physical symptoms which result from alcohol or drug use?
Yes ____ No ____ If yes, describe: _____
_____
What was the date of your last physical? _____
Are you pregnant Yes _____ No _____ Not Sure _____
Do you have any physical disabilities? Yes _____ No _____
If yes, please explain: _____
Are you currently receiving social security disability? Yes _____ No ____
Do you have any dental needs? Yes _____ No ____
If yes, please explain: _____
Do you wear glasses? _____When was your last eye exam? _____
Do you have any speech problems? Yes _____ No _____
If yes, please explain: _____
Do you have any hearing problems? Yes _____ No _____
If yes, please explain: _____
Do you smoke cigarettes? Yes _____ No ____
If yes, how much do you smoke? _____
If no, have you ever smoked in the past? Yes _____ No _____
If yes, when and how much? _____
Have you ever quit or tried to quit smoking in the past? Yes _____ No _____
If yes, what happened? _____
If you smoked prior to incarceration, do you plan to start smoking again upon release?
Yes _____ No _____
Chronic/ongoing conditions:

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_____
_____
_____

Times hospitalized in Past Year: _____
Past Surgeries? _____
Can you stand for long periods of time? How long? _____ How many pounds can you lift? 20lbs? 30lbs? 40(+) lbs.? _____

Mental Health

Do you have a current or history of mental health diagnosis (Yes or No?):
Please explain: _____
Age of 1st Mental Health Diagnosis? _____
Do you agree with this diagnosis? _____
Why or Why not? _____
Who provides you with Mental Health treatment? _____
List Medications and dosages: _____
_____
_____
Are these medications covered by insurance or other resources?_____ Do you take your medications as prescribed by physician?_____
Have you ever abused you MH medication? _____
Concerns regarding mental health: _____
Have you ever abused you MH medication? _____
At what age did you start taking MH medication? _____
Have you ever been hospitalized for any other psychiatric reasons? _____
If so Why/When/Where? _____
Was there any mental illness in your family or origin? Yes _____ No _____
If yes, describe: _____

Have you ever been diagnosed with an Eating disorder?
Anorexia? _____ Bulimia? _____ Both? _____
How many treatments have you had for the Eating disorder? _____
How many times did you successful complete treatment? _____

Suicidal/Homicidal Ideation

Is there a history of suicide in your family? _____
Have you ever attempted suicide? Yes_____ No_____
If yes, please explain: _____
_____
Do you feel that you would like to injure yourself or someone else? Yes _____ No____
If yes, please explain: _____
_____
Are you depressed at this time? Yes, a lot _____ Yes, a little _____ No _____

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Domestic Violence

As a child did you experience or witness domestic violence? Yes_____ No_____
If yes, please explain: _____
_____
Have you ever been involved in domestic violence personally?
Either as the Perpetrator or as a Victim: Yes_____ No_____
If yes please to either, please explain: _____

Trauma

Have you ever experienced any of the following traumas? Please explain and list age.
Neglect _____ Age _____
Separation from primary caregiver _____ Age _____
Family Secrets _____ Age _____
Emotional abuse _____ Age _____
Physical abuse _____ Age _____
Witness any abuse of others _____ Age _____
_____
Alcohol/ drug abuse by childhood caregivers' _____
_____
Have you been Sexually Abused? _____
If so by whom? _____
Age of 1st abuse? _____
Do you still have a relationship/s with this person/s? _____
Have you experienced Domestic Violence: _____
By Who? _____ Do you still have a relationship/s with this person/s? _____
Explain: _____
Do you have a history of Human or Sex Trafficking (Yes or No?)

Criminal Justice:

If you are currently incarcerated, please answering the following:
Where are you Incarcerated? _____
What is your sentence: _____ Release Date? _____
Legal Status: Parole_____ Probation_____ Pending_____
Any Pending Charges/Cases if yes, please list: _____
_____
Circumstances required for parole/probation: _____
_____
Other Criminal History: _____
Felonies: _____
If yes, please list the year: _____
Are you on Probation or Parole: ANYWHERE: _____County: _____
Name of P.O. _____Phone Number: _____
Are you a registered sex offender? _____
Have ever been the preparatory of Violent Crime to another person? _____

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Have you ever been convicted of a violent crime? _____
Are you court ordered to attend treatment services? _____
Do you have a driver's license? _____
If no, why? _____
When was the last time you had a driver's license? _____
Do you have any kind of picture identification? _____
If yes, what kind? _____
Have you filed for Social Security or Social Security Disability? _____
When and how many times? _____
Please list any other legal concerns? _____
_____
_____
Do you have a copy of your birth certificate? _____
Do you have a social security card? _____

Debt

Do you have debt? _____ If yes what is the last known amount owed? _____
Who do you owe and the amount owed? _____

Family History:

Who in your family do you have a relationship with?

Are you currently in a relationship? Yes or No
If yes what is there name? _____
What is your highest level of education? _____
Parents: Mother _____ your relationship with her _____
Father _____ your relationship with him_____ Siblings: _____ Gender/Age _____
_____ Gender/Age _____
_____ Gender/Age_____
Family traumas? _____
Are you Married, Single, Widower/d, Divorced, separated (please Circle all that apply)
Times Married: _____
Current Husbands/Significant Others Name: _____
When married: _____ When Divorced/Separated_____
When married: _____ When Divorced/Separated_____
Number of Children: _____
List below:
Name_____ Sex_____ Age _____ Do you have custody? Yes_____ No _____
Name_____ Sex_____ Age _____ Do you have custody? Yes _____No _____
Name_____ Sex_____ Age _____ Do you have custody? Yes _____No _____
Name_____ Sex_____ Age _____ Do you have custody? Yes _____No _____
If you do not have custody, who does? _____
Are your children in Foster Care? Yes _____ No _____
What are the circumstances of children's welfare at this time? _____
_____
_____

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Have you ever run a household by yourself? Yes _____ No _____
If so describe: _____
As friends, do you prefer women or men? _____
What are your hobbies? _____
What do you do in your spare time? _____
_____
_____
List hobbies that you hope to learn: _____

Education

Are you able to read? _____
Highest grade completed: _____ GED: Yes_____ No _____
Where did you attend school? _____ Years? _____
_____ Year? _____
_____ Year? _____
Do you want to continue your education? _____
Do you have student loans? _____
If yes, please explain: _____

Sexual History

Have you received an STD test recently? _____ If so, when/where? _____
Do you currently have an STD? _____. If so, are you being treated for it? _____
Who do you receive treatment from? _____
History of sexual violence:
Incest _____
Assault _____
Harassment _____
Rape _____
Other _____

Religious Background and Faith Journey

What has your Faith Journey been like so far?
_____
_____

What is your worse fault? _____
What is your best trait? _____
Religious Affiliation: _____
Please list any issues that may have affected your regard to religion: _____
_____
_____
Place of Worship: _____ Religious Leader _____
Do you attend worship service? Yes_____ No _____
If yes, how often? _____
Do you participate in religious-based activities outside of worship services?
Yes _____ No _____ If yes, explain: _____

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Income

List any sources of Income: _____

Have you applied for assistance through other agencies, including Social Security? Yes/ No Details if yes.

_____

_____

Are you willing to apply for Food Stamps? Yes or No _____

Are you willing to live in a recovery home for at least two years, during the intensive Treatment part of the program?

Yes _____ No _____

I, the undersigned, am requesting services from the staff of Gateway. I understand that this facility provides full IOP and EOP services and that no specific outcome can be guaranteed. I further understand that my full cooperation with all agency and organization personnel and services and following all requirements of the treatment program and the recovery home is mandatory in order to remain in treatment and fulfill probation/parole requirements.

I hereby agree to the release of any and all medical or other information required to verify the information provided herein. Further, I understand that providing false information herein is grounds for immediate dismissal from the Gateway to Discovery Program regardless of when discovered.

Signature of Applicant: _____ Date: _____

Person Completing Intake: _____ Date of Intake: _____

Once selected from the waiting list, the applicant will be required to attend a face-to-face interview in Fort Dodge with the director.

During Within a week of the interview the director will call with the acceptance or denial. Upon acceptance an arrangement to tour the house and the program's social enterprise, Hope Sweet Hope Studios will be set. During this time the applicant will be introduced to the other women living in the house.

The applicant should plan on spending three hours in the interview and meet-and-greet processes. After the interview and meet-and-greet processes, the applicant may be asked to receive a mental and physical evaluation. For any questions regarding the entrance process of Gateway to Discovery, please call Carmen at (515) 302-8162.

Note: Referrals must contact Gateway staff on a weekly basis to remain active on the waiting list. (515) 302-8162