



### The Journey

1933 North 1120 West Provo, Utah 84604  
 1-800-208-7780 Director 801-885-7244 Fax (801) 375-4241

## The Post at Impact Ranch Residential Treatment Program Demographic and Emergency Information

Client:	Age:	DOB:	Gender:	Case #:	SSN:	Date of Entry:
Guardian/CM:	Phone: Cell:	Fax: Email:	Location:			
Mother:	Phone: Cell:	Address:		Emergency Contact/Phone:		
Father:	Phone: Cell:	Address:		Health Insurance:		
Physician:	Phone:	Address:		Policy Number:		
Identifying Information: Primary Language Spoken: _____ Parents' Primary Language Spoken: _____						
Race:	Hair Color:	Eye Color:	Height:	Weight:		
Identifying Marks/tattoos: _____						

## Application

Primary Reason for Referral: Court Ordered: <input type="checkbox"/> yes <input type="checkbox"/> no	
Does the client have any physical disabilities? <input type="checkbox"/> yes <input type="checkbox"/> no Does the client have any medical concerns? <input type="checkbox"/> yes <input type="checkbox"/> no Does the client need detoxification at this time? <input type="checkbox"/> yes <input type="checkbox"/> no Does the client have a history of mental illness? <input type="checkbox"/> yes <input type="checkbox"/> no Does the client have a history of violent offenses? <input type="checkbox"/> yes <input type="checkbox"/> no Does the client have a history of sexual offenses? <input type="checkbox"/> yes <input type="checkbox"/> no Is the client on medication currently? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please list medications: _____  Any other concerns for the client: _____	Comments: _____
Please include the following documentation with this application: <input type="checkbox"/> Court Order <input type="checkbox"/> Signed Purchase Service Contract <input type="checkbox"/> Physical/Dental Exam Results (Will provide if Medicaid) <input type="checkbox"/> Medicaid Card (Copy)	<input type="checkbox"/> Traveling File Information, to include: <input type="checkbox"/> Past Psychological Evaluations <input type="checkbox"/> Personal History <input type="checkbox"/> Educational Records <input type="checkbox"/> Medical History
<b>Program Use Only:</b> _____ meets the admission criteria for The Journey/The Post Program. This client is not experiencing any severe physical reactions to substance abuse or substance abuse withdrawal at time of admission. Admission Date: _____ Therapist: _____ Clinical Director's Signature: _____ Date: _____	