



The Journey

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 Director (801) 885-7245 Fax (801) 375-4241

True Path 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: _____	Comments:
Any other concerns for the client: _____	
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
Program Use Only: _____ meets the admission criteria for The Journey. 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: _____	