



www.vitalityunlimited.org

## RESIDENTIAL ADMISSION FORM

Admissions Department: Cell 775-934-8537 | Fax 775-461-0512

email: [intake@vitalityunlimited.org](mailto:intake@vitalityunlimited.org)

Date: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Caller Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### APPLICANT INFORMATION

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address \_\_\_\_\_  
PO Box or Street City State Zip

Email \_\_\_\_\_ Social Security No. \_\_\_\_\_

Race: \_\_\_\_\_ Sex:  Male  Female Gender Identity:  Male  Female  Other

Are you currently incarcerated?  No  Yes Incarceration date: \_\_\_\_\_ Anticipated release date: \_\_\_\_\_

**All questions must be answered. Do not leave a question unanswered or blank. If the question doesn't apply to you, write NA in the space provided.**

### TREATMENT HISTORY

Have you ever been a Vitality client?  No  Yes Date of prior admission to a Vitality facility: \_\_\_\_\_

Did you successfully complete?  No  Yes Reason for leaving? \_\_\_\_\_

Number of prior admissions to mental health or alcohol or drug treatment facilities including detox: \_\_\_\_\_

Types:  Residential (Substance Use)  Residential (Mental Health)  Intensive Outpatient (IOP)  Outpatient

Location and date of the most recent treatment: \_\_\_\_\_

### MEDICAL HISTORY

What medications are you taking? \_\_\_\_\_

Do you require any of the following?  Oxygen  Wheelchair  Walker  No

Do you require any assistance with activities of daily living?  No  Yes If yes, explain: \_\_\_\_\_

**Please check if you are currently experiencing or have ever experienced the following:**

Pregnant If you are pregnant, how many months? \_\_\_\_\_  Allergies - food  Allergies - medications

Please explain any medical issues you are dealing with: \_\_\_\_\_

## SUBSTANCE USE PAST AND PRESENT

What was the first substance/drug you used? \_\_\_\_\_ How old were you when you started using? \_\_\_\_\_

Please mark whether the substance is a primary or secondary drug of choice, including alcohol.

Substance	Date of last use	No. of years used	Amount	Frequency	Method of use
<b>Alcohol</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-2 drinks <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> Other
<b>Methamphetamines</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 0.5 grams <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3.5 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhalation <input type="checkbox"/> Smoking
<b>Cocaine</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 0.5 grams <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3.5 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhalation <input type="checkbox"/> Smoking
<b>Heroin/Opiates</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 0.5 grams <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3.5 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhalation <input type="checkbox"/> Smoking
<b>Marijuana</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 0.5 grams <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3.5 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> Inhalation <input type="checkbox"/> Smoking
<b>Club Drugs</b> <small>(Ecstasy, Molly, Acid, GHB)</small> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-3 doses <input type="checkbox"/> 4-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> Inhalation <input type="checkbox"/> Other
<b>Sedatives/Tranquilizers</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-3 doses <input type="checkbox"/> 4-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhalation <input type="checkbox"/> Smoking
<b>Prescription Medications</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-3 doses <input type="checkbox"/> 4-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhalation <input type="checkbox"/> Other
<b>Inhalants</b> <small>(canned air, paint thinner, etc.)</small> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-2 inhales <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7 or more	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Inhalation <input type="checkbox"/> Other
<b>Tobacco/Nicotine</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-5 uses <input type="checkbox"/> 5-9 <input type="checkbox"/> 10-20 <input type="checkbox"/> 21 or more	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> Inhalation <input type="checkbox"/> Smoking
<b>Synthetic Drugs</b> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-2 uses <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7 or more	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhalation <input type="checkbox"/> Smoking
<b>Medication Assisted Therapy</b> <small>(Methadone, Suboxone, Vivitrol)</small> <input type="checkbox"/> Primary drug <input type="checkbox"/> Secondary			<input type="checkbox"/> 1-3 doses <input type="checkbox"/> 4-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> Other	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhalation <input type="checkbox"/> Other

## LEGAL

Are you currently involved with the legal/judicial system? No Yes If yes, explain: \_\_\_\_\_

Have you ever been arrested for, charged with, or convicted of a sexual crime? No Yes

If yes, explain and tell us your Tier Level: \_\_\_\_\_

Have you ever been arrested for, charged with, or convicted of a violent crime including domestic offenses? No Yes

If yes, what were the charges? \_\_\_\_\_

If yes, when? \_\_\_\_\_ Have you ever been arrested for arson? No Yes

Were you under the influence at the time you committed any crimes? No Yes

## MENTAL HEALTH

Do you have a current mental health diagnosis? No Yes What is the diagnosis? \_\_\_\_\_

While clean and sober have you ever experienced seeing or hearing things that others said were not there? No Yes

If yes, explain: \_\_\_\_\_

Have you ever thought of ending your life? No Yes If yes, how recently? \_\_\_\_\_

Have you planned how you would kill yourself? No Yes Do you have the means at hand/available? No Yes

Were you under the influence of drugs/alcohol when you were having thoughts about ending your life? No Yes

Have you made suicide attempts? No Yes If yes, how many? \_\_\_\_\_ When? \_\_\_\_\_

## REFERRAL INFORMATION

How did you hear about Vitality Unlimited? Facebook/Instagram Vitality website Google Radio Other

Who referred you to Vitality Unlimited? \_\_\_\_\_

Do we need to notify someone of your admission? No Yes If yes, please provide us with the contact information

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## INSURANCE INFORMATION

Do you have active insurance? No Yes

Primary Insurance \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Member number \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Member number \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

**Please review this questionnaire. Make sure you have answered every question before submitting the form.**

I have provided this information for the purpose of admission to the Vitality Unlimited Residential Program in Carson City or Elko. It is complete and accurate to the best of my recollection.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PLANNING FOR TREATMENT AT VITALITY

Please limit the amount of luggage you bring to treatment.

1. **Free** your schedule of all obligations and appointments: legal, medical, dental, CPS, court, etc. You must take care of your pending issues prior to entering treatment.
2. You will need two (2) forms of identification such as a driver's license, photo ID, or Social Security card.
3. If uninsured, you must have proof of household income for the past calendar year. Paycheck stubs, W2s, tax returns or a notarized letter from an acceptable agency.
4. **MEDICATION:** If you are taking prescribed medication, it is your responsibility to provide them.
  - **BRING AT LEAST A 30-DAY SUPPLY OF ALL APPROVED MEDICATIONS.**
  - Admissions Coordinator must approve all medication during the application process.
  - If you have unauthorized medication in your possession upon admission, it will be destroyed.
  - Health Plan of Nevada clients must be prepared to pay for their medications.
  - All clients regardless of their payor source, e.g. private or public health insurance will be charged for Blister Packs – a required method used to package your medication.
5. **CLOTHING:** Vitality Unlimited's dress code is strictly enforced. Staff will confiscate any clothing deemed inappropriate. The confiscated clothing will be returned at the time of discharge. Bring enough clothing and undergarments (socks, underwear, bras) for seven (7) days. Please do not overpack. We have laundry facilities.
  - Pants must fit properly and shouldn't have holes or rips. We do not allow skin-tight or sagging pants.
  - Clothing that is considered provocative, gang related, drug and alcohol related, or otherwise overtly controversial, is not allowed.
  - Certain clothing may not be suitable. Hooded shirts or sweatshirts are only allowed to be worn outside.
  - It is mandatory for clients to sleep in pajamas or sweatpants and T-shirts.
  - Slippers are needed and a robe is suggested. We don't allow clients to wear open-toed shoes.
  - Please be mindful of the time of year and bring seasonally appropriate items.
6. **HYGIENE PRODUCTS:** Read all product labels. Products containing alcohol are not allowed. Aerosols of any type (hairspray, foot spray, deodorants) are not allowed. You should bring your personal toiletries: soap, toothbrush, toothpaste, deodorant, sunscreen, body lotion, shampoo, conditioner, hair dryer, curling iron, etc.
7. For journaling or writing letters bring non-wire bound notebooks/pads, stamps, and envelopes.
8. All clients will be charged \$50.00 per trip for medical transport. Medicaid clients are excluded.
9. We are a tobacco-free and vape-free facility, but you may purchase lozenges from Vitality for \$30 a box. Each box contains 80 lozenges. The facilities accept cash or debit/credit cards. Nicotine patches are available through prescription.
10. Communication with family and friends will be restricted to written form for the first ten (10) days of treatment.
11. Vitality Unlimited will not be liable for lost or stolen items. Please leave valuables at home.

## **DO NOT BRING THE FOLLOWING ITEMS TO TREATMENT AT VITALITY**

3-Ring binders	Condoms	iPods	Spiral notebooks
Alcohol	Cough drops	Knives	Tattoo guns
Ballpoint pens	E-cigarettes	Latex/Nitril rubber gloves	Television
Bed linens or sheets	Electric razors	Markers	Tobacco replacement products
Beverages	Electric toothbrushes	Mechanical pencils	Tools
Bicycles	Electronic games	Mouthwash	Towels
Camera	Food	Nail polish or remover	Un-authorized prescriptions
Candy	Gum	Nicotine patches (opened)	Vape juice
CD/DVD players	Guns	Paraphernalia	Vapes
Cell phones	Herbs	Perfume	Vitamins
Cigarettes	Highlighters	Radio	Weapons
Colognes	Illegal drugs	Scissors	
Commit lozenges	Ink/Gel pens	Sharp objects	

**If any of the above-mentioned items are brought to Vitality, they will be removed or may be destroyed.**