# Lincoln Trail Behavioral Health System
# Willows Application

Please complete this form in its entirety and return via mail or fax:

Willows Program
Attn: Intake Department
Lincoln Trail Behavioral Health System
3909 South Wilson Road
Radcliff, KY 40160

Fax Number: 270-352-2832
or
270-351-0400
Phone Number: 270-351-9444

| | | |
|---|---|---|
| Name: | Date of Birth: | Age: |
| Social Security Number: | | |

| | | | |
|---|---|---|---|
| Guardian Name: | | Relationship: | |
| Home: | Work: | Cell: | Fax: |
| Address: | City/St: | | Zip: |

*If guardian is* **DJJ / DCBS / CDW** (circle one), *then fill out the following*:

| | | | |
|---|---|---|---|
| Assigned Worker's Name: | | Supervisor's Name: | |
| Phone #: | On-Call #: | Fax: | |
| Address: | City: | St: | Zip: |
| Date client was committed to the State: | (please return with copy of custody papers) | | |
| Reason for commitment to the State: | | | |
| Termination of Parental Rights? YES / NO | Date: | | |

*If currently hospitalized please complete the following:*

| | | |
|---|---|---|
| Hospital Name: | Case Manager: | Admit Date: |
| Primary Diagnosis: | Physician: | Est. D/C Date: |

## Presenting Problem/Need for Specialized Program: (within past month)

## Current/History of Sexualized Behaviors:

***Please provide information regarding the following sexualized behaviors as it pertains to the client:***

### Masturbation:

### Inappropriate behaviors and/or sexual abuse of other children:

### Inappropriate behaviors and/or sexualize behaviors towards animals:

**Inappropriate online and/or social media interactions including sexting:**

_____

_____

_____

_____

## TRAUMA HISTORY

**Sexual Abuse: YES / NO Age of Client: _____ Was it reported: YES / NO**

**Perpetrator(s): _____**

**Detailed account of abuse: (please include duration)**

_____

_____

_____

_____

**Outcome for Client and Perpetrator:**

_____

_____

_____

_____

**Physical Abuse: YES / NO Age of Client: _____ Was it reported: YES / NO**

**Perpetrator(s): _____**

**Detailed account of abuse: (please include duration)**

_____

_____

_____

_____

**Outcome for Client and Perpetrator:**

_____

_____

_____

_____

**Emotional Abuse: YES / NO Age of Client: _____ Was it reported: YES / NO**

**Perpetrator(s): _____**

**Detailed account of abuse: (please include duration)**

_____

_____

_____

_____

**Outcome for Client and Perpetrator:**

_____

_____

_____

_____

## LEGAL HISTORY

**Any legal charges against client: YES / NO**

***If yes*, please list all current and past charges:**

_____

_____

_____

**Please list any upcoming court dates: (please include if client presence is needed)**

_____

## RISK FACTORS

**History of suicidal ideations, suicide attempts and/or self-injurious behaviors: (please include methods, dates and severity)**

_____

_____

_____

_____

**History of homicidal ideations, attempted homicides and/or assaultive behaviors: (please include dates and severity)**

_____

_____

_____

_____

**History of property destruction, running away, bedwetting, animal cruelty, fire setting and/or PICCA:**

_____

_____

_____

_____

_____

## SUBSTANCE ABUSE HISTORY

**Is the client currently abusing drugs or alcohol: YES / NO**

**Does the client have a history of drug or alcohol abuse: YES / NO**

***If yes*, please provide detailed information regarding usage and past treatment for substance abuse:**

_____

_____

## DEVELOPMENTAL HISTORY

**Maternal alcohol and/or drug use during pregnancy: YES / NO**
***If yes*, please provide substance and duration of usage during pregnancy:**

_____

_____

**Prenatal Trauma and/or Developmental Delays: YES / NO**

***If yes*, please provide details including any additional services needed:**

_____

_____

**History of traumatic brain injury (TBI): YES / NO**

***If yes*, see attached addendum to provide more information.**

## FAMILY HISTORY

**Family history of mental illness: YES / NO**

***If yes*, please provide family member's relationship and mental illness:**

_____

_____

_____

**Family history of substance abuse: YES / NO**

***If yes*, please provide family member's relationship and drug of choice:**

_____

_____

_____

**Has any family member been convicted of a sexual offense: YES / NO**

***If yes*, please provide relationship and charge:**

_____

**Has any family member been incarcerated: YES / NO Currently: YES/NO**

***If yes*, please provide details:**

_____

_____

## EDUCATION AND COGNITIVE FUNCTIONING

**Name of School: _____ Current Grade: _____**

**Has the client repeated a grade: YES / NO *If yes*, which grade(s): _____**

**Does the client currently have an IEP, 504 Plan or require any special education and/or needs in the school system: YES / NO**

***If yes*, please describe: (It is required to attached most recent IEP and/or 504 Plan)**

_____

_____

**Does the client have trouble reading or writing: YES / NO**

***If yes*, please detail and include current grade level of abilities:**

_____

**Does the client have a history of being suspended: YES / NO**

***If yes*, please detail behaviors and dates of suspensions:**

_____

_____

**Has the client been diagnosed with MR, MMR or PDD: YES / NO**

***If yes,* please provide name of practitioner who diagnosed client as well as their current cognitive functioning level:**

_____

_____

**What is the client's Full Scale IQ: _____ Date Tested: _____**

## TREATMENT HISTORY

**Current and/or Past Inpatient Treatment History**

| Facility | Dates of Treatment | Diagnosis/Reason for Admission |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Current and/or Past Outpatient Treatment History**

| Agency | Dates of Treatment | Diagnosis | Provider Name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## MEDICAL

**Please check all that apply:**

- ○ **Pregnancy**
- ○ **Diabetes**
- ○ **Hepatitis**
- ○ **Open Wounds**
- ○ **GERD**
- ○ **Vision Problems**
- ○ **Asthma**
- ○ **Cardiac**
- ○ **STD(s)**
- ○ **Enuresis**
- ○ **Brain Injury**
- ○ **Eating Disorder**
- ○ **Seizure Disorder**
- ○ **Hypertension**
- ○ **High Cholesterol**
- ○ **Encopresis**
- ○ **Hearing Problem**
- ○ **Other**

**Please provide detailed information for all medical illnesses above:**

_____

_____

_____

**Has the client had a TB skin test: YES / NO Date/Results: _____**

**Has the client ever had surgery: YES / NO**

***If yes*, please provide type of surgery and date of surgery:**

_____

_____

**Does the client have any medication allergies: YES / NO**

***If yes*, please provide name of medication and reaction:**

_____

_____

**Does the client have any food or other allergies: YES / NO**

***If yes*, please provide allergen and reaction:**

_____

_____

**Does the client currently have or previously had MRSA: YES / NO**

***If yes*, please provide wound area and date of infection:**

_____

**Current Medications**

| Medication | Dose | Route | Frequency | Prescriber |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## DIAGNOSIS (Adherent to DSM 5)

**Psychiatric**

_____

_____

**Medical**

_____

_____

**Stressors**

_____

_____

**I agree that all the information given is to be true:**

**Application Completed By:** _____

**Agency:** _____ **Date:** _____

**Parent/Guardian Signature**: _____ **Date**: _____

**To ensure timely processing of the client's application, please attach the following documents when returning the application:**

- **Copy of most recent medical card**
- **Current IEP and/or 504 Plan**
- **Custody and/or Court Papers of Guardianship**
- **Letter of referral from M.D. or qualified mental health professional**
- **Psychiatric and/or Psychological Evaluation (if available)**
- **Full Scale IQ (if available)**
- **Progress Notes from current placement (if applicable)**

## ADDENDUM: Traumatic Brain Injury Information

**Age that TBI was acquired: _____**

**Please detail incident in which TBI occurred:**

_____

_____

**TREATMENT HISTORY**

**Did the client require surgery: YES / NO**

***If yes*, please provide what type of surgery, age of client at the time of the surgery and facility in which surgery was performed:**

_____

_____

**Is the client currently under the care of a neurologist: YES / NO**

***If yes*, please provide neurologist name, address and phone number OR**

***If no*, please provide family physician's name, address and phone number:**

_____

_____

_____

_____

**Does the client require any type of additional therapeutic services such as occupational therapy, physical therapy or special education: YES / NO**

***If yes*, please provide information regarding type of services and current provider of services:**

_____

_____

**Does the client have medical issues complicated by TBI: YES / NO**

***If yes*, please describe:**

_____

_____

**Does the client suffer from memory loss, blackouts, impulsivity and/or compulsive behaviors that is attributed to TBI: YES / NO**
***If yes*, please detail complications:**

_____

_____

**Please attach a copy of client's most recent neurological visit, CT scan results and/or MRI results. If client requires additional therapeutic services please attach a copy of the most recent therapy progress notes.**