

# Lincoln Trail Behavioral Health System

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 to: 270 352 2832  
 or  
 270 351 0400

In Compliance with **HIPPA Security and Privacy Rule**, please fax information without client's name or SS#. A follow up phone call will allow for client's name and SS# to be shared.

Name:	Age:	Date of Birth:	SS#:
-------	------	----------------	------

**ADOLESCENT INFORMATION NEEDED**

Guardian name:	Relationship	State Custody? <i>YES / NO</i>
Phone #:	(W):	Cell: Fax:
County:	Address:	City/St: Zip

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

Assigned Worker's Name:	Supervisor's Name:
Phone #:	On-Call #: Fax:
Address:	City: St: Zip:
Date client was committed to the State:	<i>(Please include custody papers when sending)</i>
Reason for commitment to the State:	

**Need Following Documents:** *(Please send as you gather or receive them so they can be recorded)*

- Copy of most recent Medical Card
- Copy of Birth Certificate
- Current Immunization Records
- School Records & current IEP *(if applicable)*
- Custody Papers/Court Papers
- History & Physical by a Physician
- Psychiatric Assessment
- Psychological Assessment
- Full Scale IQ
- Nursing Notes from previous treatment facilities *(if requested)*
- DSS 886-A *(if in State Custody)*
- Letter of Referral from M.D. *(Please call the Admissions Department first for specifics)*

**Reason for Referral/Presenting Problem:**

---

---

---

---

---

● *History of Inappropriate Sexualized Behavior or Sexually Reactive Behaviors: Examples to include but not limited to: (please check if applicable)*

- When a child touches other children in a sexual way that is not age-appropriate.
- Shows excessive interest/curiosity in sex that overrides other activities.
- When a child continues to have sexual behaviors even after being re-directed by an adult.
- Talks excessively about sexuality, or has inappropriate knowledge of sexuality for their age.
- Harms or touches animals in a sexual way.
- Exchanges gifts or shows affection to others in order to have sexual contact, either to other children or adults (*grooming behaviors*).
- Touches a child younger or someone from a vulnerable population by displaying more power & control.
- Excessive masturbation.

Age of when behavior began? \_\_\_\_\_ Describe the behavior and towards whom: \_\_\_\_\_

---

---

**Past 2 months** of acting out behavior: \_\_\_\_\_

**Past 6 months** of acting out behavior: \_\_\_\_\_

Any **legal charges** against client? **YES/NO** *If yes, please describe the charges:* \_\_\_\_\_

Please list any upcoming court dates: \_\_\_\_\_

**Client Support**

Who is the client's main support system? \_\_\_\_\_

Is there a termination of parental rights? \_\_\_\_\_

**History of Trauma**

---

Sexual Abuse: **YES/NO** Age of Client then: \_\_\_ Abused by: \_\_\_\_\_

Describe the abuse & for how long was the client subjected to it? \_\_\_\_\_

---

Was it reported? **YES/NO** What was the outcome? \_\_\_\_\_

---

Physical Abuse: **YES/NO** Age of Client then: \_\_\_ Abused by: \_\_\_\_\_

Describe the abuse & for how long was the client subjected to it? \_\_\_\_\_

---

Was it reported? **YES/NO** What was the outcome? \_\_\_\_\_

---

Emotional Abuse: **YES/NO** Age of Client then: \_\_\_ Abused by: \_\_\_\_\_

Describe the abuse & for how long was the client subjected to it? \_\_\_\_\_

---

Was it reported? **YES/NO** What was the outcome? \_\_\_\_\_

---

**Family History**

---

Substance Abuse: **YES/NO** Describe: \_\_\_\_\_

Psychiatric Illness: **YES/NO** Describe: \_\_\_\_\_

---

Does client have a history of suicidal/homicidal ideation, assault or self injury behavior: **YES/NO**

If yes, Please describe: \_\_\_\_\_

---

Does the client experience any nightmares? YES / NO \_\_\_\_\_

Does the client have any phobias or fears? YES / NO Describe: \_\_\_\_\_

---

**Previous Treatment**

Facility	Dates	Diagnoses

**Medication Profile**

Medication	Dosage	Route	Frequency

**Education**

Current Grade *(please circle)* 1 2 3 4 5 6 7 8 9 10 11 12 School Name: \_\_\_\_\_

Does client have trouble reading or writing? YES / NO

Does the client have an IEP or require any special needs in the school system? YES / NO Describe: \_\_\_\_\_

What is the client's Full Scale IQ? \_\_\_\_\_ Date Tested: \_\_\_\_\_

**Diagnosis**

Axis I : \_\_\_\_\_

Axis II : \_\_\_\_\_

Axis III : \_\_\_\_\_

Axis IV : \_\_\_\_\_

Axis V : \_\_\_\_\_

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

Application Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the Client : \_\_\_\_\_

Client Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_