



# Jackson-Feild Behavioral Health Services

546 Walnut Grove Drive Jarratt, VA 23867  
Admissions@jacksonfeild.org

PH: (434) 634 – 3217  
Cell: (434) 637 – 0995

Fax: (877) 991 – 8711

## **APPLICATION FOR ADMISSION**

**(BLACK INK ONLY)**

I hereby apply for admission of this individual to Jackson-Feild Behavioral Health Services, Inc.:

**Patient:** Is this a readmission? Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Gender: \_\_\_\_\_ Race/Nationality: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_

Present Age: \_\_\_\_ Years \_\_\_\_ Months Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

### **Agency and/or Person Making Application on Behalf of Patient:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address (Agency, if applicable):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
Emergency/After Hrs. No. \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

### **Legal Guardian, if not the same as above:**

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

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work: \_\_\_\_\_

### **PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE**

#### **1. Where (with whom) is the patient currently residing?**

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

Address: \_\_\_\_\_



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2. Reason(s) for current treatment intervention: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Has the patient been in any residential intervention within the last two years? Yes \_No \_\_\_\_

4. List in chronological order the names of all treatment interventions received within the past two years (e.g., residential, out-patient, hospitalizations, mentoring, home-based):

Previous Treatment Intervention(s)	Type of Facility	Dates		Successful?	
		From	To	Yes	No

Transition Type (Foster Care, Relative, Shelter, Other Out of Home)	Dates		Relationship/Connection	
	From	To		
Total # of Transitions				

5. Identify the current symptoms exhibited by the patient:

**Behavioral Symptoms**

- \_\_\_\_ Physical Aggression  
 If Yes, date of most recent: \_\_\_\_\_
- \_\_\_\_ Verbal Aggression  
 If Yes, date of most recent: \_\_\_\_\_
- \_\_\_\_ Homicidal acts
- \_\_\_\_ Suicide attempts  
 If Yes, number of attempts: \_\_\_\_\_  
 If Yes, date of last attempt: \_\_\_\_\_
- \_\_\_\_ Running away
- \_\_\_\_ Ignores rules

- \_\_\_\_ Gang Affiliation
- \_\_\_\_ Stealing
- \_\_\_\_ Truancy
- \_\_\_\_ Fire starting
- \_\_\_\_ Property destruction
- \_\_\_\_ Substance Abuse  
 If yes, list substance (s): \_\_\_\_\_  
 If yes, date of last reported use: \_\_\_\_\_

Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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### Socioemotional Symptoms

- |  |  |
|--|--|
| <input type="checkbox"/> Sad/depressed mood        | <input type="checkbox"/> Hearing/seeing things others don't  |
| <input type="checkbox"/> Grief                     | <input type="checkbox"/> Non-suicidal self-harming (cutting) |
| <input type="checkbox"/> Low self-esteem           | <input type="checkbox"/> Manipulation                        |
| <input type="checkbox"/> Mood swings               | <input type="checkbox"/> Poor impulse control                |
| <input type="checkbox"/> Distractible              | <input type="checkbox"/> Dishonesty                          |
| <input type="checkbox"/> Impulsive                 | <input type="checkbox"/> Bed wetting                         |
| <input type="checkbox"/> Poor concentration        | <input type="checkbox"/> Weight changes                      |
| <input type="checkbox"/> Anxiety/constant worrying |  |

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Interpersonal Symptoms

- Promiscuity
- Inappropriate sexualized behaviors with same age peers
- Inappropriate sexualized behaviors with younger peers
- Inappropriate sexualized behaviors with older peers
- Prostitution
- Survivor of human trafficking

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Significant Life Events:** Has the patient experienced or is suspected to have experienced any trauma, abuse, violence, neglect, conflict, or significant loss that impacts current functioning?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. Treatment Needs and Referring Behaviors:** What are the treatment needs and/or actual behaviors for which the patient is being referred and Jackson-Feild Behavioral Health Services that staff will need to address for discharge goals?

**A. Mental Health, Emotional and Psychological Needs:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Educational Needs:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. Physical Health Needs, Including Immunizations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**D. Religious Affiliation, and Needed Accommodations, if any:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**E. Are there any special protective measures that should be enforced during patient’s residential intervention?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F. Behavioral Support Needs:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. What is the discharge plan for this patient?** \_\_\_\_\_  
\_\_\_\_\_

Target Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**8. What is the attitude of the parents/caregivers & the patient towards this residential intervention?** \_\_\_\_\_  
\_\_\_\_\_

**9. Describe parental involvement, if any:** \_\_\_\_\_  
\_\_\_\_\_

**10. History of Court Involvement:** \_\_\_\_\_  
\_\_\_\_\_

Please list all charges and the results/status of each, including status offenses below:

Charges	Date	Results/Current Status

Is the patient presently on probation? Yes \_\_\_\_ No \_\_\_\_ (If yes, attach probation rules)

If so, for what charge? \_\_\_\_\_

Name of Probation Officer: \_\_\_\_\_

Next Court Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

Is the patient court-ordered for treatment? Yes \_\_\_\_ No \_\_\_\_ (If yes, attach court order)



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**11. Indicate any special needs concerning treatment, health and/or safety (include any restraints or constraints that the facility may have to enforce, support, or provide etc.):**

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**12. Describe the patient’s strengths, areas of interest, and/or supports that may help motivate the patient throughout treatment (e.g. names of people, hobbies, talents, areas of previous success, competencies or expressed interests):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**13. What has worked best with this patient in the past?** \_\_\_\_\_

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**14. When has the patient been most successful?** \_\_\_\_\_

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## Medical Information

Does the patient have health insurance coverage? Yes\_\_\_ No \_\_\_

Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Past serious illnesses or infectious diseases: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Medical problems: \_\_\_\_\_

\_\_\_\_\_

Current medication(s): \_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of last physical (please attach): \_\_\_\_\_

Condition: \_\_\_\_\_

Date of Last dental exam (please attach): \_\_\_\_\_

Follow-up needed: \_\_\_\_\_

Date of last psychological (please attach): \_\_\_\_\_

Condition: \_\_\_\_\_



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Date of last neurological (if applicable, please attach): \_\_\_\_\_  
Condition: \_\_\_\_\_

**IQ Scores**  
Verbal \_\_\_\_\_ Performance \_\_\_\_\_ Full Scale \_\_\_\_\_ Date \_\_\_\_\_

Patient's physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Patient's dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

## **Family Information**

### **MOTHER:**

Full name: \_\_\_\_\_  
(First) (Middle) (Last) (Maiden)

Present address: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Work telephone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Marital status: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Religious preferences: \_\_\_\_\_

Occupation (type of work & company): \_\_\_\_\_

Monthly Salary: \_\_\_\_\_ Serious illness: \_\_\_\_\_

If deceased: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cause: \_\_\_\_\_

### **FATHER:**

Full name: \_\_\_\_\_  
(First) (Middle) (Last)

Present address: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Work telephone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Marital status: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Religious preferences: \_\_\_\_\_

Occupation (type of work & company): \_\_\_\_\_

Monthly Salary: \_\_\_\_\_ Serious illness: \_\_\_\_\_

If deceased: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cause: \_\_\_\_\_

### **SIBLINGS:**

Name	Sex	DOB	Address	Serious Illness?



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List other significant family members: \_\_\_\_\_

Are there any persons with whom this child cannot have contact? Yes \_\_\_ No \_\_\_  
(If “yes” please list names below)

Name (First and Last)	Relation / Association

Other relevant information concerning family involvement in treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Educational Information

Name of Patient: \_\_\_\_\_

Last Public School Attended: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Last Date of Attendance: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Has the patient attended any other specialized school? Yes \_\_\_\_\_ No \_\_\_\_\_

School Attended: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Last Date of Attendance: \_\_\_\_\_

Scholastic performance (academic strengths, weaknesses, school behavior & goals): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Attendance:

Attends regularly \_\_\_\_\_

Often misses school \_\_\_\_\_

Occasionally misses school \_\_\_\_\_

Has not been attending school \_\_\_\_\_

Is this applicant identified as a special education student? Yes \_\_\_\_\_ No \_\_\_\_\_

If this patient has an IEP, please have the form on the next page signed by the parent or legal guardian. This will give us time to arrange the appropriate changes in their IEP



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## CONSENT FORM FOR TRANSFER STUDENT

### Educational Services

As part of \_\_\_\_\_'s residential intervention at Jackson-Feild Behavioral Health Services, we would like to provide the most effective educational program we possibly can. In our goal to continue and/or develop an educational program which will best facilitate this student's General or Special Education success, we would like your consent for the following:

- A. To use his/her current IEP until we can meet to make the appropriate changes consistent with his/her present residential intervention (a meeting will be scheduled within the first five (5) days of placement).
- B. To consider the option of obtaining a General Education Diploma.
- C. To administer educational assessments in order to determine academic functioning and progress.

I give my consent for the aforementioned actions of Gwaltney School.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

Along with this completed application please be sure to include the items spelled out on the "documentation required" form. Please do not omit any questions on this application. If you do not know the answer please state that accordingly, or put "n/a" where applicable. Please take the time to include dates where applicable as well.

***Thank you so much for entrusting Jackson-Feild Behavioral Health Services in meeting this child's psychiatric needs.***

Person/Agency Authorized to Place Applicant: \_\_\_\_\_

If agency, name and title of authorized agent: \_\_\_\_\_

Application submitted by: \_\_\_\_\_

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date