

Dedicated to Promoting Individual, Family and Community Wellness Through a Variety of Substance Abuse and

To: Prospective Resident

Thank you for requesting information about New Frontier Treatment Center.

New Frontier (NFTC) would like to take this opportunity to inform you of the variety of programs and individual treatment plans we offer to help meet your special needs. Whether this is your first attempt at change or you are a veteran of a previous rehabilitation program we believe that our program can be of great help to you. Our professional staff and peers are available to help you achieve this goal. All agency programs are state licensed and accredited.

Listed below are the residential services offered at New Frontier Treatment Center.

Level III.2D – Social Model Detox – NFTC can admit detox clients into services Monday thru Sunday 24 hrs. Detox screening may take place over the telephone or face-to-face in the case of a “walk-in”. The maximum capacity for detox services is 2 males or 2 females. **Medical clearance** will be required before a client can be admitted. Client is responsible for any prescribed medication.

Level III.3 - Clinically Managed Medium Intensity Residential Treatment – How long does residential care last? The programs at New Frontier Treatment Center are not defined by a number of days, but rather by individual needs. Lengths of stay for the residential program are dependent on the needs of the individual and are determined through an assessment process. Successful treatment is the ultimate goal, and time is necessary to triumph the battle. The first week is an assessment period to determine if residential and any other services are needed by the client. If New Frontier Treatment Center determines that residential services can be provided, then the client will be re-evaluated each week to determine treatment progress. Clients will be attending group sessions, individual counseling, substance abuse education classes, recreation, and may be introduced to Twelve Step meetings.

Level III.1 - Clinically Managed Low Intensity/Advanced Recovery Residential Treatment– this is a less intensive program and is a longer commitment with the possibility of up to six months depending on client’s need. Clients in this program have successfully completed the medium intensity residential program. Clients in the program are required to fill out a daily goal plan to let staff know their whereabouts throughout the day and obtain approval from staff. Clients are required to follow their schedule explicitly, find employment within one week of entering this level of treatment, attend weekly inpatient meetings, obtain a sponsor within one week of entering this level, attend group sessions and individual counseling, and maintain a clean living environment. Clients in Level III.1 residential treatment pay weekly on their treatment bill, which varies depending on client’s income level

OFFICE LOCATION	ADMINISTRATION	BOARD OF DIRECTORS	
1490 Grimes Street Fallon, NV 89406-2919 Ph: (775) 423-1412 Fax: (775) 423-4054	Lana Henderson, Executive Director Mandy Rigsby, Clinical Director Valerie Pacheco, Operations Manager Debbie Ridenour, Human Resources	Jim Wood, Chairman Joe Lane, Treasurer James Richardson, Member	Vaughna Bendickson, Vice-Chairman Ron Marrujo, Member Susan Chambers, Member Bob Bridges, Member

New Frontier's fees are based on a sliding scale so that all clients entering our programs regardless of income can afford treatment. New Frontier Treatment Center's program requests a housing fee according to the SAPTA sliding fee scale schedule. All clients being admitted for residential treatment are drug tested at time of arrival and there is a \$35.00 UA/BA fee and \$75.00 for a physical. Unless other arrangements have been made with the financial department, these fees will be requested at admittance. New Frontier Treatment Center now has the capability to accept Nevada Welfare Quest Card, Visa or MasterCard to pay for treatment costs. In some instances private insurance may cover a portion of residential services. Unfortunately, Medicare does not cover residential services. **Verification of income must accompany completed Inpatient Application.**

New Frontier Treatment Center is also a non-smoking, tobacco-free facility. The use of tobacco products is prohibited in or on New Frontier's property. The suggestion is to become tobacco free for 72 hours prior to admit. In addition, New Frontier Treatment Center offers help with those who wish to stop using tobacco products. Our nicotine dependence program including pharmacotherapy's is available to all residential clients.

Enclosed you will find a copy of New Frontier Treatment Center application. Please complete the following forms and either fax or mail the completed application to the Intake Department at the number or address listed below. **** Incomplete applications will not be accepted.**

MAIL/FAX TO: Intake Department/Residential Treatment
1490 Grimes Street
Fallon, Nevada 89406
Ph: (775) 423-1412
Fax: (775) 423-4054
1-800-232-6382

The Intake Department will contact you after your application has been received. If you do not receive a call within 5 days, please call to check on the status of your application.

If you have any further questions, please do not hesitate to contact New Frontier during business hours of 8:00 a.m. – 5:00 p.m. Monday-Friday at (775) 423-1412.

Sincerely,

New Frontier Administration

1490 Grimes Street
Fallon, Nevada 89406
Ph : (775) 423-1412 or 1 (800) 232-6382 Fax: (775) 423-4054

Office Use Only:

Date Application Received: _____ Admission Date: _____ Client NHIPPS No. _____

APPLICATION

All information must be completed in order for application to be processed

Personal Information (please print)

Date: _____

Last _____ **Middle** _____ **First** _____
Home Address _____ City _____ County _____
Temporary Address _____ City _____ County _____
State _____ Zip _____ Years at Address _____
Booking # _____ Prison Back Number: _____
Home # () _____ Work # () _____ Message # () _____ Cell# () _____
Social Security # _____ DOB: _____
Gender: Male/Female / Transgender: Yes/No

Race: Please circle answer

None Selected / Alaska Native (Aleut, Eskimo, Indian) / American Indian (Other than Alaskan Native) Asian / Native Hawaiian other Pacific Islander / Black or African White / Other Single Race / Two or more Races / Unknown

Ethnicity: Please circle answer

Unknown / White (not of Hispanic origin) / Black (not of Hispanic origin) American India/ Alaskan Native / Asian or Pacific Islander / Hispanic-Cuban / Other Hispanic

Religion: *None Protestant Catholic Jewish Islamic Other None*

Mother's First Name (1st 3 Letters) _____

Client's Birth City _____

Caller Identity: *Self Family member Friend Employer Other*

US Citizen: Yes / No

Veteran: *Not a veteran / Vet w/honorable discharge / Vet w/other than honorable discharge Active Duty / Unknown*

Permanent

Contact _____

Phone No. _____

Circle One: Adult or Youth

Health Insurance:

No health insurance /Medicaid/Medicare /Champus/VA / Private w/o Substance Abuse Coverage
CHIPS / Private Substance Abuse Coverage
Other public funds /health care: _____

Marital / Social History:

Current marital status: ___Married ___Divorced ___Separated ___Single ___Widowed

Pregnant: _____Yes _____No Due Date: _____

Number of Children: _____ Ages: _____

Are they currently in your care? ___Yes ___No

Referral Source: _____ Contact Name: _____ Phone #: _____

1. Why do you want or need residential or outpatient treatment? _____

2. What are your top 3 drug of choice? (Including Alcohol)

Drug Choice #1: _____

Drug Choice #2: _____

Drug Choice #3: _____

3. Date of last use and drug type: _____

4. Are you an I.V. user? ___Y ___N How long have you been an I.V. user? _____

5. Have you made attempts to cut down or quit before? _____

6. Are you able to stay clean on your own? _____

7. Have you been seen by a physician? ___Yes ___No

8. Date of last medical exam? _____

9. Have you experienced medical problems in the past thirty days? ___Y ___N

10. History of DT's or Seizures? ___None ___Mild ___Moderate ___Severe

12. Do you have a history of hallucinations? ___Yes ___No

13. Do you have any medical issues? ___Yes ___No (Explain) _____

14. Any mental health issues? ___Y ___N

Diagnosis: _____

15. Do you have any physical/mental disabilities that may interfere with treatment or for which you may need special accommodations? ___Y ___N

(If yes, please explain) _____

16. Are you taking any medication? ___Yes ___No

How long have you been taking the medication? _____

If pregnant, have you received medical care including prenatal vitamins? ___Yes ___No

List medication:

Medication Reason Medication Reason

A _____ B _____

C _____ D _____

17. Medical/Dental appointments scheduled? ___Y ___N

List dates: _____

18. Current physician's name and location of medical records: _____

19. Indicate if you have had any of the following health problems: Please circle Yes or No

- | | | | | | |
|----|---------------------|-------|-----|---------------------|-------|
| 1. | Hear Disease | Y / N | 9. | Liver Disease | Y / N |
| 2. | Stroke History | Y / N | 10. | Hepatitis (A, B, C) | Y / N |
| 3. | High Blood Pressure | Y / N | 11. | Tuberculosis | Y / N |
| 4. | Internal Bleeding | Y / N | 12. | Respiratory | Y / N |
| 5. | Ulcers | Y / N | 13. | Epilepsy | Y / N |
| 6. | Hospitalizations | Y / N | 14. | Recent Surgery | Y / N |
| 7. | Diabetes | Y / N | 15. | S.T.D. | Y / N |
| 8. | Head Trauma | Y / N | 16. | Allergies | Y / N |

Do you have any of the following contagious illness or conditions? Please circle Yes or No

Head lice Y/N Pin Worms Y/N Strep Throat Y/N Pink Eye Y/N
 Athlete's Feet Y/N Ring Worms Y/N Flu (influenza) Y/N SARS Y/N

Other: _____

20. Any history of physical or sexual abuse? ___Yes ___No
 21. Any special needs or concerns about writing or reading? ___Yes ___No
 22. Have you ever been convicted of a sex crime? ___Yes ___No
 If yes, please explain and give date: _____

23. Have you ever been convicted of a violent crime? ___Yes ___No
 If yes, please explain and give date: _____

24. How long have you been incarcerated? _____ Reason for incarceration _____

25. Probation/Parole Officer: _____ Phone: _____
 Other Court dates, outstanding warrants, miscellaneous legal information: _____

26. List names and dates of treatment programs that you have participated in for Residential or Outpatient for substance abuse and/or mental health.

Name	_____	Date/Year	_____
Name	_____	Date/Year	_____
Name	_____	Date/Year	_____

27. Do you have any legal issues or court dates? ___Yes ___No
 County/State of Court _____
 Court Dates _____ Any outstanding Warrants? _____

28. Are you ordered by CPS, Court, probation or parole, Counselor, Physician, Social Worker, CPS, Etc. into treatment? ___Yes ___No

List contact names and numbers: _____

List reason(s) for order: _____

29. If treatment is order by the legal system or a local agency, what are the conditions? _____

30. Please list dates available for treatment. (A.S.A.P will not be accepted as appropriate response). _____

31. Are you employed? _____ If yes, employers name _____
 Address _____ Phone # _____

Is your employer aware of your current situation? ___Yes ___No

32. If unemployed, last job held: _____ When: _____

33. If on Disability, how long: _____ Why: _____

34. Any work problems related to reason for admission? ___Yes ___No
 35. Have you worked in the last 6 months? ___Yes ___No
 36. What is your monthly income amount? _____ Source? _____
 37. How will you pay for treatment? _____
 38. Do you have insurance/Medicaid/Medicare/TANF? If yes, insurance:
 Name _____ Policy number _____ Group number: _____

Smoking /Tobacco Products: Effective July 1, 2002, NFTC is a total non-smoking/tobacco free environment.

Waiting List

You do have the option of being placed on the waiting list for the next available bed. Please keep in mind that New Frontier Treatment Center uses their priority list to determine who is next in line for the next available scheduling date. To be placed on the waiting list it is mandatory to have a phone number where you or a representative you designate by a signed release can be reached to request placement on the first available bed. Please list first and last name of the person to be contacted is someone other than you.

SAPTA (Substance Abuse Prevention Treatment Agency) Defined Interim Services

Please check one of the following:

Pregnant Injecting drug user _____ Pregnant user _____
 Injection user _____ Other abusers _____

Name: _____
 Phone # _____

Emergency Contact Name: _____ Phone # _____
 Signature: _____ Date: _____

MAIL TO: Intake Department
 1490 Grimes Street
 Fallon, Nevada 89406
 Ph: (775) 423-1412
 Toll Free: (800) 232-6328
 Fax: (775) 423-4054

Intake staff will contact you after your application has been received. If you do not receive a call within 5 days, please call to check on the status of your application.

If you have any further questions, please do not hesitate to call New Frontier during business hours of 8:00 a.m. – 5:00 p.m. Monday-Friday at (775) 423-1412.

Residential Client Information Sheet

Processing Information

When submitting your application, the following information will be required to complete the process:

- Verification of income – pay stub, bank statements, last tax documentation or proof of income from any agency or local service provider
- Available dates for treatment
- Referral source name, phone and fax numbers, if available.

Due to our limited scope of practice, we request any reports describing the client's legal history to determine appropriateness for treatment

Payments

At time of admittance:

- New Frontier Treatment Center request that clients being admitted pay the housing fee or unless other arrangements have been made with the financial department. (Housing fee may be higher depending on income level.)
- Drug testing fee \$35.00 – UA/BA
- Physical fee \$75.00
- Medication fee \$50.00 - \$200.00 depending on client's medical needs.
- Payment arrangements will be made for the remaining balances for treatment.
- Some insurance companies cover part or all of the costs of treatment at New Frontier Treatment Center. Please call the financial department for further information.
- Medicare does NOT cover the cost of residential treatment.
New Frontier Treatment Center now has the capability to accept Nevada Welfare Quest Card (Food Stamps), VISA and MasterCard to pay for treatment costs.

Confirming Bed Dates

Clients are required to confirm all bed dates the Friday before check-in. Clients may have someone confirm on their behalf. Not confirming can result in the loss of the bed-date and the rescheduling at New Frontier's earliest convenience.

Admittance

- To be admitted to New Frontier Treatment Center, all clients will be drug tested. Those who test positive will be screened by the Clinical Director, and if needed, sent to Banner Churchill Community Hospital for medical clearance. Once clearance has been obtained, the client will be admitted either to the social model detox or the residential program.
- Clients that are felons are required to register with the local authorities. Please do so prior to arriving at New Frontier Treatment Center.
- Be sure to have all prescription medications filled, and have an adequate amount for the duration of your stay. New Frontier Treatment Center staff members are not responsible for payments or filling of prescriptions. No over-the-counter medications will be allowed, and will be confiscated and held in the safe to be returned at time of discharge.

Medications that are not allowed to be taken while in treatment include mind/mood altering substances and muscle relaxers. We request that if you are taking any prescribed medication that you are on them at least two full weeks prior to your admittance, and if you have recently stopped taking prescribed medication that you are off them for at least two full weeks prior to admittance.

Phone Calls

Clients admitted to New Frontier Treatment Center will be required to have a calling card to make phone calls, or calls will be made collect. While in treatment, clients will be allowed a certain amount of phone calls on a case by case basis. In addition client will make one phone call within 48 hours of admittance and one prior to discharge.

Mail

- Clients in treatment are allowed to send and receive mail/letters.
- Clients must supply their own stamps and envelopes.
- Care packages are **NOT** allowed.

New Frontier will not accept any C.O.D. packages or packages with insufficient postage due.

Family Group Counseling

The Family Group Counseling session is held every Sunday from 1:00p.m. to 3:00 p.m. **THIS IS NOT A VISITATION.** Children under the age of 13 are not allowed to attend. This is a time to address any family issues or concerns and to facilitate family involvement.

Visitation

Scheduled visitations are on Sunday from 1:00 p.m. to 3:00 p.m. and are for immediate family members. Visits by non-family members and visits during non-scheduled days are approved on a case-by-case basis. The *Client Visitation Rules* form must be completed by all visitors prior to any visit.

Physical

Physical examinations are completed within seven (7) days of admission. Clients are requested to get a physical examination prior to treatment. If a client is incarcerated or due to an unforeseen circumstance you may make prior arrangements in with New Frontier for your physical. If a client had a physical examinations within the last 30 days prior to admission this will be accepted. Any physical given past 30 days prior to admission will not be accepted as a client's condition of history changed at the time of admission.

SMOKING POLICY

NEW FRONTIER TREATMENT CENTER IS A NON-SMOKING & TOBACCO-FREE FACILITY. THE USE OF TOBACCO PRODUCTS IS PROHIBITED IN OR ON ANY NEW FRONTIER TREATMENT CENTER OWNED/LEASED PROPERTIES (BUILINGS, VEHICLES, PARKING LOTS, ADJACENT SIDEWALKS AND PROPERTIES.) NEW FRONTIER TREATMENT CENTER DOES OFFER A SMOKING CESSATION PROGRAM FOR THOSE NEEDING ASSISTANCE OR YOU CAN CALL THE AMERICAN CANCER SOCIETY AT (800)227-2345 OR THE RENO OFFICE AT (775)329-0609.

Client are encouraged to bring a supply of nicotine patches, lozenges, and gum during their stay at New Frontier.

Client Acknowledgement Signature

Date

HEALTH HISTORY

(CONFIDENTIAL)

NAME: _____ TODAY'S DATE: _____

AGE: _____ BIRTHDATE: _____ DATE OF LAST PHYSICAL EXAMINATION: _____

WHAT IS YOUR REASON FOR INITIAL VISIT?

SYMPTOMS: Check symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE & THROAT	MEN Only
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Appetite Poor	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Chills	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred / Double Vision	<input type="checkbox"/> Erection Difficulties
<input type="checkbox"/> Depression	<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Lump in Testicles
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Penis Discharge
<input type="checkbox"/> Fainting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Glasses / Contacts	<input type="checkbox"/> Sore on Penis
<input type="checkbox"/> Fever	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Ear Discharge	WOMEN Only
<input type="checkbox"/> Headache	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bleeding Between Periods
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Extreme Menstrual Pain
<input type="checkbox"/> Numbness	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Sweats	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Nipple Discharge
MUSCLE / JOINT / BONE	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Painful Intercourse
Pain, Weakness, Numbness in:	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Vision – Flashes	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Arms	CARDIOVASCULAR	<input type="checkbox"/> Vision – Halos	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Hips	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Dentures	<input type="checkbox"/> Other
<input type="checkbox"/> Back	<input type="checkbox"/> High Blood Pressure	SKIN	
<input type="checkbox"/> Legs	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Bruise Easily	Last Menstrual Period?
<input type="checkbox"/> Feet	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Hives	Last Pap Smear?
<input type="checkbox"/> Neck	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Itching	Mammogram?
<input type="checkbox"/> Hands	<input type="checkbox"/> Rapid Heartbeat	<input type="checkbox"/> Change in Moles	Are You Pregnant?
<input type="checkbox"/> Shoulders	<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Rash	Number of Children?
<input type="checkbox"/> Right Knee	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Scars	Number of Pregnancies?
<input type="checkbox"/> Left Knee		<input type="checkbox"/> Sore that Won't Heal	
GENITO – URINARY			
<input type="checkbox"/> Blood in Urine			
<input type="checkbox"/> Frequent Urination			
<input type="checkbox"/> Lack of Bladder Control			
<input type="checkbox"/> Painful Urination			
<input type="checkbox"/> Difficult Urination			

CONDITIONS: Check conditions you have had in the past.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Ulcers / Irritable Bowels
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mumps	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Polio	
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostate Problems	
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Hernia	<input type="checkbox"/> Psychiatric Care	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Bulimia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Suicide Attempt	
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Tonsillitis	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Tuberculosis	

MEDICATIONS: List medication you are currently taking. (Include Over-the-counter drugs) **ALLERGIES:** To Drugs, Food, Substances etc.

Medications you should be taking and are not?	Prescribed for?	Last Taken?

**HEALTH HISTORY – Page 2
(Confidential)**

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relative has or had: Diseases	Relationship
Father					<input type="checkbox"/> Arthritis, Gout	
Mother					<input type="checkbox"/> Asthma, Hay Fever	
Brothers					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Chemical Dependency	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease, Strokes	
					<input type="checkbox"/> High Blood Pressure	
Sisters					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Depression or Psychological Illness	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex at Birth	Complications If Any

Have you ever had a blood transfusion? Yes No
If Yes, please give approximate date(s)

Date	Serious Illness / Injuries	Outcome	HEALTH HABITS	Check which substance you use, how often, how much
			<input type="checkbox"/> Caffeine	
			<input type="checkbox"/> Tobacco	
			<input type="checkbox"/> Drugs	
			<input type="checkbox"/> Alcohol	
			<input type="checkbox"/> Gambling	
			<input type="checkbox"/> Other	

OCCUPATIONAL CONCERNS
Check if your work exposes you to the following: Explain:

<input type="checkbox"/> Stress		Occupation?	
<input type="checkbox"/> Hazardous Substances		Hours per Week?	
<input type="checkbox"/> Heavy Lifting		Education?	
<input type="checkbox"/> Personnel Conflict			
<input type="checkbox"/> Other			

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date

Witness Signature

Date

Letter of Explanation of Currently Prescribed Medications

New Frontier Treatment Center requires a doctor's letter on all prescribed medications completed by the prescribing physician before entering treatment.

Please list all prescribed medications with dosages, what condition the medication is being taken for:

Medication Name	Dosage	Condition Treated
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

Physician Signature

Date

New Frontier Treatment Center Requirement List

We will **NOT** go to the store at any time during treatment.

What **TO** Bring:

- Five to seven days of comfortable clothing
- Toiletry items such as shampoo, deodorant, shaving gear, hygiene products, etc. (**no alcohol based products**) – please bring your own as you are not allowed to share these items with other clients
- NA/AA type material/Bible
- Writing materials, envelopes, postage stamps and blue ink pens, 3 ring binder.
- Current TB test results.
- Two towels, two washcloths
- Laundry detergent and laundry bag/basket
- Housing fee according to the SAPTA sliding fee scale
- \$35.00 drug testing fee UA/BA.
- \$75.00 for physical upon admit unless other arrangements have been made).
- \$50.00-\$200.00 for potential medical needs.
- Medicine in opened containers or containers w/o labels/improperly labeled or outdated will be sent home or destroyed
- Medication-Doctor prescribed (30 day supply for each medication prescribed).
- Bring a phone card for outside phone calls.
- Bring current insurance card and Medicaid card if applicable.
- Nicotine patches, lozenges, and gum if applicable.
- Slippers and Shower Shoes.
- Current Assessment if available
- ID card or Driver license.
- Optional-Bring pillow and blanket
- Personal Water bottle for recreation

What **NOT** to Bring:

- **NO** short shorts/skirts, tank tops/sleeveless clothing, midriff tops, baggy pants or gang apparel
- **NO** clothing with inappropriate language, content or pictures/drawings.
- **NO** perfumes, colognes, aerosols, fingernail polish or polish remover or nail glue
- **NO** books, magazines or non-recovery reading material
- **NO** tobacco products
- **NO** cell phones, pagers, radios, walkman, disk-man, laptop computers, TV's, CDs, cassette tapes, alarm clocks, etc
- **NO** jewelry allowed. (This includes tongue rings, or body piercing jewelry).
- **NO** credit cards on the facility.
- **NO** automobiles on the New Frontier property.
- **NO** Money is allowed on the unit

(New Frontier will not be held responsible for lost or stolen items.)

Please Remember!!!

You must confirm your bed date with us and be on time for admission, failure to do so may result in losing your reservation. We would then reschedule your bed date at our convenience.

- Absolutely no one will be admitted without a confirmed Intake appointment - unless other arrangements have been made in advance.
- All pregnant women must have a medical release by a physician and an adequate supply of pre-natal vitamins/medicines for the stay
- Head east on US 50 (Williams Ave.) turn right on Allen Rd. (at McDonalds), then left on Grimes St. to 1490.

Transportation to and from New Frontier is your responsibility!!!

Client Signature

Date

Witness Signature

Date

CONTRABAND

Because we are a secure Center, and because we want to protect the safety of all the people at NFTC there are some things that are prohibited from being on the grounds of NFTC.

These items will be confiscated and held secure as contraband or destroyed. Contraband items are defined: “Anything that can function as a weapon, instrument of self-harm or otherwise poses a threat of injury.

Alcoholic beverages (beer, wine, whiskey), firearms handguns, shotguns, rifles, ammunition, and illegal drugs such as marijuana and cocaine.

Aerosol containers

Butane Lighters

Glass or metal objects

Knives or any item that could be used as a knife, such as ice pick, screwdriver, etc.

Matches

Dangerous items will be sent home. Confiscated contraband items are listed in the client file, secured and returned to the client upon discharge. Clients are encouraged to send valuables and cash home.

Approved Medications

For Pain- Anacin Bufferin Excedrin Tylenol Bayer Aleve
 Advil Motrin Ibuprofen Midol Pamprin

- The "Extra Strength" versions of the above medication is approved to take
- Do not take any "Cold and Sinus" , "Allergy" or "Flu" versions of the above medication

PRESCRIPTION NON-NARCOTIC PAIN MEDICATIONS:

Naprosyn Mutrin Mobic

DO NOT TAKE ANY PAIN MEDICATIONS WITHOUT PRIOR APPROVAL. This includes: Vicodin Percocet Darvocet Lortab Tylenol w/Codine Vicoprofen

THIS INCLUDES MUSCLE RELAXANTS SUCH AS: Soma Robaxin

For Allergies- Benadryl Allergy (Pink Box)
 "Simply Allergy" from Tylenol
 Equate Allergy (Pink Box)
 Tylenol "Severe Allergy" (Yellow Box)

For Colds- Alka-Seltzer Plus Cold (Blue Box)
 Alka-Seltzer Plus Flu (Orange Box)
 Alka-Seltzer Plus Cold & Cough (Purple Box)
 Chlor-Trimeton (Green Box)
 Dristan Cold Original (Red Box)
 Robitussin DM (ONLY the DM version)
 Vicks 44m Cough & Chest Congestion (Purple Box)
 Vicks 44m Cough Relief (Green Box)
 Honey Cough by Robitussin (Green Box)
 Afrin No Drip Nasal Spray (Purple Box)
 Any Halls Cough Drops
 Vicks Vapor Rub (Don't Eat It)

****Do NOT take any "Liquid Cap" version of the above medication**

For Stomach Aches- Tums Roloids Maalox Pepto-Bismol
 Gaviscon Mylanta Tagament HB Ex-Lax
 Imodium Gas-X Pepcid Prilosec

****Sealed and unopened medication bottles/containers only**

****You MUST take the correct amount of the above medication**

****Only Regular vitamins may be taken**

****DO NOT TAKE ANY HERBAL SUPPLEMENTS OR HERBAL DIET AIDS**

10. Which drugs or alcohol caused you the MOST serious problems? See list below.

	Drug Name	# of days used in the last 30 days
Primary Substance	_____	_____
Secondary Substance	_____	_____
Tertiary Substance	_____	_____

11. How often did you inject drugs with a needle? Circle answer
Never / Only a few times / 1-3 times a month / 1-5 times a month / about every day

12. How serious do you think your drug problems are?
Not at all / Slightly / Moderately / Considerably / Extremely

13. How many times before now have you ever been in an alcohol treatment program?

14. How many times before now have you ever been in a drug treatment program?
(do not include AA/NA/CA meetings)

15. Do you think you need treatment for your drug use now?
If "Yes," answer question "a" below:
a. How important to you is it that you get into some type of treatment program now?
Not at all / Slightly / Moderately / Considerably / Extremely

16. How many times have you received psychiatric or counseling services for reasons other than alcohol or drug problems?
(Include all hospitalization and outpatient visits)

17. Do you currently have a medical condition?
If "YES" Choose no more than 3 conditions below: Circle answer

Seizures	GI Bleeding	Gastritis/Ulcers	Anema	Hepatitis	HIV
STD	TB	Heart disease	Hypertension	Diabetes	Cancer
Malnutrition	Respiratory	Lung Disease	Injuries	Other	

Other Medical Conditions? _____

18. What medications have been prescribed or have you been taking in the past 6 months for substance abuse or mental health problems?

_____	_____
_____	_____
_____	_____
_____	_____

a. If female, are you pregnant? Yes/No

- **GAMBLING BEHAVIORS**

19. How old were you the first time you gambled (bet money or something of value on sports, a game of chance or skill, played the lottery, or bet cards or dice games/?)
20. In the last 30 days, have you gambled for anything of value?
21. If you have gambled in the past 12 months, how much money did you usually bet?
22. In the past year, have you often found yourself thinking about gambling or planning to gamble?
23. In the past year, have you ever spent more than you meant to on gambling?
24. In the past year, has gambling lead you to lie to your family?
25. Has the money you spent gambling led to financial problems?
26. Has the time you spent gambling led to problems in your family, work, school, or personal life?

