Please mail or fax back the information listed below. Daybreak Admissions needs this information prior to giving out a bed date. If the needed information has not been completed or unable to obtain please contact the admissions department for more direction.

- ☐ **Daybreak Admission Packet (Page 1-4)**
- ☐ **Copy of Recent Drug and Alcohol Assessment**
- ☐ **Records from Mental Health Counselor and Past treatment centers.**

Information needed by time of scheduled intake:

- ☐ **Copy of a Recent Physical and TB Test**
- ☐ **Immunization Record**

Female Applicants, please address your packet to:

Daybreak Youth Services
Attention: Admissions Department
628 S. Cowley St.
Spokane, WA 99202-1377

or

Male Applicants, please address your packet to:

Daybreak Youth Services
Attention: Admissions Department
2924 Falk Road, Suite 102
Vancouver, WA 98661-5604

Diane Lenier - Spokane Inpatient Admission Coordinator
Phone: (509) 624-3227, x-1003 Fax: (509) 835-4272
email: dlenier@daybreakyouthservices.org

Michelle Baird - Vancouver Inpatient Admission Coordinator
Phone: (360) 750-9588, x-3000 Fax: (360) 750-9718
email: mbaird@daybreakyouthservices.org

Client's Full Name: ______________________ Gender: ☐ Male ☐ Female Transgender

Address: ______________________ City: __________ State: ______ Zip: ______

Phone # __________ SS#: __________ Age: ______ DOB: __________ Grade: ______

Parent/Guardian Name: ______________________ Relationship to client: __________ DOB: __________

Address: ______________________ City: __________ State: ______ Zip: ______

SS#: __________ E-mail Address: ______________________ Home Phone: __________

Legal Custody: ◯ YES ◯ NO Name of Work Place: ______________________ Daytime Phone: __________

Parent/Guardian Name: ______________________ Relationship to client: __________ DOB: __________

Address: ______________________ City: __________ State: ______ Zip: ______

SS#: __________ E-mail Address: ______________________ Home Phone: __________

Legal Custody: ◯ YES ◯ NO Name of Work Place: Daytime Phone:

Client lives with: ◯ Both Parents ◯ Mother Only ◯ Father Only ◯ Relatives* ◯ Foster Care* ◯ Friends ◯ Other*

***Name:** ______________________ Relationship to client: __________

Address: ______________________ City: __________ State: ______ Zip: ______

E-mail Address: __________ Home Phone: __________ Daytime Phone: __________

Does person listed above have legal custody of youth? ◯ YES NO If no, then who?

PARENT/GUARDIAN: Please complete the following.

Client Disability? (Circle)

Mobility Vision Hearing Developmentally Disabled Learning Mental/Psychological None Other______________________

Ethnicity: Asian Black/African American White/Caucasian Hispanic/Latino Native American Other:__________

NEAREST FRIEND NOT LIVING WITH YOU: ______________________ Phone #__________

NEAREST RELATIVE NOT LIVING WITH YOU: ______________________ Phone #__________

PRIMARY PHYSICIAN: ______________________ Phone #__________

OUTPATIENT COUNSELOR:______________________ Phone #__________

PROBATION OFFICER: ______________________ Phone #__________

CASEWORKER: ______________________ Phone #__________

INSURANCE INFORMATION: Do you have: (Circle) Private Insurance Medicaid

PRIMARY INSURANCE: ______________________ Customer Service Phone:__________
Subscriber Name: ______________________ Member ID# __________
Subscriber Daytime Phone# ______________________ Group # __________

SECONDARY INSURANCE:______________________ Customer Service Phone:__________
Subscriber Name: ______________________ Member ID# __________
Subscriber Daytime Phone# ______________________ Group # __________

****SIGNATURE of person financially responsible for client account:** ______________________

Client Name ______________________________ **Age**______

Client's current Legal Status:

- ☐ On probation or parole
- ☐ ARY (AT RISK YOUTH)
- ☐ Involved in Sex Offender Court
- ☐ Involved in drug Court?
- ☐ Diversion Program
- ☐ Awaiting charges/trial

Has the youth ever had any of the following? (Please check all that apply.)

- ☐ Prior arrests for drug offenses
- ☐ Prior arrests for other public order offenses
- ☐ Prior arrest for property crimes
- ☐ Prior arrest for property crimes
- ☐ Prior arrests for domestic violence
- ☐ Prior arrest for sexual misconduct

Has the client been charged with any of the following crimes?

Arson ___________ Forgery ___________ Robbery ___________

Assault ___________ Homicide___________ Shoplifting _____________

Burglary _________ Probation Violations __________ Weapons Offense ________

Contempt of Court __________ Prostitution _______ Other _____________

Drug Related Violations______ Rape _____________

Please provide us with any additional information about the legal history that would be helpful to us as we work with this youth.

____
____
____
____
____
____
____
____
____
____

Probation Officer _____________________ **County** _____________________

Phone Number ( ) ___________________ **Fax** ( ) ___________________

Email ______________________

What are the legal consequences if treatment is not successful:

- ☐ Client will receive a probation violation.
- ☐ Client will go to detention for ________ days.
- ☐ Client will receive NO legal consequences.

Client Name ______________________________Age______

FAMILY HISTORY OF ALCOHOL/DRUG USE

All information provided will be held in accordance with state and federal confidentiality laws.

Please complete the following chart to the best of your ability

Relationship to youth (mother, father, grandparent, sibling, etc.)	Type of drug used	Currently using? YES/NO	Live with youth ?	Frequency of Use: How often?	Is use seen as a problem? Diagnosed as addicted?

1. Is there anyone else in this youth's life that currently uses drugs? (Friends, boyfriend, friends of the family?)

____

2. Has anyone in the youth's immediate family been charged with any drug/alcohol related offences?

____

3. Has anyone in the family been in chemical dependency treatment in the past? ☐ Yes ☐ No ☐ Don't Recall

If yes, who? And did they complete the program?

____

4. Are they currently in recovery? ☐ Yes ☐ No ☐ Don't Recall

5. Helping the family to deal with family problems, including the chemical use/abuse/addiction of family members is an essential part of the recovery process. Please share with us any concerns that you may have about discussing family patterns of addiction.

____

INFORMATION FOR RELEASES

Please list below names and information for Parents/Guardians, **previous Treatment Centers**, Probation Officers, Caseworkers, Mental Health Therapists, Family Therapists, Insurance Company, Medical Clinic and/or Medical Physician, Dentist or anyone that we may need to talk to or get information from in order to facilitate, summarize, and coordinate continuing care.

NAME OR PROGRAM	MAILING ADDRESS	PHONE# - INCLUDE AREA CODE	FAX# OR EMAIL ADDRESS

Reviewed for compliance by:________________________
staff signature

Date: __________________ Exemption: Yes ☐ No ☐
(see back)

Certificate of Immunization Status

Washington State Law (RCW 28A.210.160) requires that all children have a completed Certificate of Immunization Status on file at the school, preschool or a child care facility that they attend. A chart showing which vaccines should be given and when is printed on the other side of this form.

Child's Last Name	**First Name**	**Middle Name**	**Sex** F ☐ M ☐	**Birthdate**
Parent/Guardian Name			**Daytime Phone**	

Immunization	Type of Vaccine	Dose	Month	Day	Year
DTP* (Diphtheria, Tetanus, Pertussis)		**1**			
		2			
		3			
		4			
		5			
		6			
POLIO (OPV by mouth, IPV by injection)		**1**			
		2			
		3			
		4			
HIB*		**1**			
(Haemophilus Influenza Type B) Label for pre-kindergarten children only		**2**			
		3			
		4			

Immunization	Dose	Month	Day	Year
MMR (Measles, Mumps, Rebella)	**1**			
	2			
	3			
HEP B **(Hepatitis B)**	**1**			
	2			
	3			
OTHER				

***Tetramune or Act-Hib is a combined vaccine of DTP and Hib. If your child receives a combined vaccine, please put date in both places.**

➡ I certify that the information provided here is correct and verifiable ⬅

X ______________________________________ DATE: ____________________
Signature of Parent or Guardian

Strengths/Protective Factors	Risks/Vulnerability Factors
Bio/Psycho	
☐ Healthy	☐ In Need of Medical Care
☐ Has a Primary Care Physician	☐ In Need of Dental Care
☐ Has seen a dentist in last 6 months	☐ Previous or Current Mental Health Condition
	☐ Hospitalization for MH symptoms
	☐ Suicide Attempt
	☐ Self Harming Behaviors
	☐ Taking Psychiatric Medications
	☐ Experienced Traumatic Event
	☐ Was a Crime Victim
	☐ Learning Disorder
	☐ More than 2 ER visits in last year
Sexual/Identity	
☐ In a Positive/Supportive Relationship	☐ Previous or Current Domestic Violence
☐ Uses Condoms and Other Protective Measures	☐ Identifies as LGBTQ
	☐ Multiple Sexual Partners
	☐ Sexually Aggressive/Offense
Family History	
☐ No Family Legal Involvement	☐ Family Member Incarcerated
☐ No Family History of Mental Health Issues	☐ Family Member with Past Legal
☐ Positive/Supportive Family Dynamic	☐ Involvement
☐ Parent Involvement In School/Services	☐ Family History of Mental Health Symptoms
☐ Family Owns Home	☐ Family History of Substance Use
☐ Biological Parents Married	☐ Family Gang Involvement
☐ Parents Maintain Stable Employment or Retired	☐ Parents Divorced
☐ Positive Relationship with Siblings	☐ Mixed Family
☐ Open Communication with Family Members	☐ Unexpected Deaths in the Family
	☐ Suicide in the Family
	☐ Period of Homelessness
	☐ Past or Present CPS Involvement
Social/Behavioral	
☐ Is Social and Engaged	☐ Has Limited Social Interactions
☐ Club/Organization	☐ Sporadic or Avoidant School Attendance
☐ Participates in School Sports	☐ Behind in School Credits
☐ Attends School Regularly	☐ Homeless/Run Away Period >3 days
☐ Grade Point Average Above 3.0	☐ Has been in a Physical Altercation
☐ Friends That Are Succesful In Following Accepted Rules	☐ History of Property Damage
☐ Close Relationships with Peers Following Accepted Rules	☐ History of Theft
☐ Religiosity	☐ Gang Involved
Legal	
☐ No Past or Present Legal Involvement	☐ Court Ordered
	☐ Forced by Family
	☐ School Requirement/Referral
	☐ AWOL from Previous Inpatient Program
	☐ Previous Agains Medical Advice Discharges
	☐ Avoided Outpatient Appointments
COMMENTS	

Client Name:___________________ **Date:**________________ **Completed by:** Relationship: