



**OGLALA SIOUX TRIBE**  
**NATIVE HEALING PROGRAM**  
**1205 EAST SAINT JAMES STREET**  
**RAPID CITY, SOUTH DAKOTA 57701**  
**PHONE (605) 342-8925**  
**FAX (605) 718-3022**



## **CO-DEPENDENCY APPLICATION**

**These documents are required to attend Co-dependency Treatment**  
**Please provide proof of tribal enrollment, a valid photo ID**

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

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

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

Cell Phone Number: \_\_\_\_\_

Message Number: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:       Male       Female

SSN: \_\_\_\_\_

Marital Status:     Single     Married     Divorced     Widowed     Separated

Number of Dependents: \_\_\_\_\_

### **INSURANCE:**

**(Please provide a copy of your card)**

Do you have Insurance?     Medicaid     Medicare     Private Health Insurance

Name of Insurance: \_\_\_\_\_

Insurance card #: \_\_\_\_\_

**PROOF OF TRIBAL ENROLLMENT AND VALID PHOTO ID (REQUIRED):**

Tribal Affiliation: \_\_\_\_\_

Enrollment #: \_\_\_\_\_

**EMPLOYMENT:**

Place of Employment: \_\_\_\_\_  Full Time  Part Time

Job Title: \_\_\_\_\_

Work Number: \_\_\_\_\_

Have Co-Dependency issues affected your job, if so how: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HIGHEST LEVEL OF EDUCATION:**

- K-6<sup>th</sup>     7<sup>th</sup>     8<sup>th</sup>     9<sup>th</sup>     10<sup>th</sup>     11<sup>th</sup>  
 12<sup>th</sup>     No Diploma     GED     AA     Bachelors  
 Masters     PhD

**REFERRAL SOURCE (Circle as many that apply):**

Employment            Relative            Friend            Newspaper            Website  
Flyer                    Radio Station            Other: \_\_\_\_\_

**SOBRIETY DATE:**

What is your Sobriety Date? \_\_\_\_\_

**PREVIOUS COUNSELING/TREATMENT:**

Name of Facility: \_\_\_\_\_

Address (does not have to be exact): \_\_\_\_\_

Successfully Completed:    YES             NO

Length of Stay:     30 days     60 days     90 days

Other: \_\_\_\_\_

**MEDICAL HISTORY:**

What do you feel is your current physical status:    Very Good     Good     Fair  
 Poor             Very poor

Date of last physical exam: \_\_\_\_\_

Date of last TB skin test: \_\_\_\_\_

Are you currently taking any medications (prescribed or over the counter):    Yes     No

If yes, please list medication: \_\_\_\_\_

\_\_\_\_\_

What is the medication prescribed for treating? \_\_\_\_\_

**ALLERGIES:**

Please list any allergies below to medications, food allergies, or seasonal.

\_\_\_\_\_

\_\_\_\_\_

**DISABILITIES:**

Please list any disabilities you might have, and any special accommodations needed for us to best serve you.

\_\_\_\_\_

\_\_\_\_\_

**SUICIDE HISTORY:**

When was your last thought of suicide? \_\_\_\_\_

When was your last attempt? \_\_\_\_\_

Were there other attempts?       Yes       No

If Yes, how many and when? \_\_\_\_\_

Place and date of last hospitalization, detox, and counseling:

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

**HISTORY OF OTHER ADDICTIONS:**

*For example: Gambling, over eater, sex, pornography (please list symptoms or concerns):*

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

**FAMILY HISTORY:**

Where did you grow up? \_\_\_\_\_

Who raised you? \_\_\_\_\_

Describe your childhood: \_\_\_\_\_

Describe any family issues: \_\_\_\_\_

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

Did your mother abuse alcohol or have a substance dependency? If so which: \_\_\_\_\_

\_\_\_\_\_

Did your father abuse alcohol or have a substance dependency? If so which: \_\_\_\_\_

\_\_\_\_\_

If raised by someone other than mother or father, did they abuse alcohol or have a substance dependency, if so which: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please write a summary of how you feel Co-Dependency treatment will benefit you:**

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**I hereby declare that I am physically and mentally competent to participate in the five (5) day Co-Dependency treatment module. Therefore, I release the Native Healing Program from responsibility or obligation for any unforeseen or unreported individual physical and mental mishap during my attendance and participation in the Co-Dependency Treatment.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

*Confidentiality Note: This e-mail is intended only for the person or entity to which it is addressed, and may contain information that is privileged, confidential, or otherwise protected from disclosure. Interception, dissemination, distribution, or copying of this e-mail or the information herein by anyone other than the intended recipient is prohibited. If you have received this e-mail in error, please notify the sender by reply e-mail, phone, or fax, and destroy the original message and all copies.*