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

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

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-6th ☐7th ☐ ☐ 8th ☐ ☐9th ☐10th ☐11th

☐ 12th ☐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?__________________________________

RELIGIOUS PREFERENCE:

Spiritual/Religious Preference:____

Actively practicing? ☐Yes ☐ No

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:

____

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

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