APPLICATION FOR OLMSTED COUNTY INTENSIVE OUTPATIENT DBT PROGRAM

Today's Date:	
Name of Applicant:	DOB:
Address:	
Phone number where you can be reached:	Can we leave a message? ☒ Yes ☐ No
Living Situation:	Gender:
Current Diagnoses:	
Current Medication:	
What is the frequency with which you take your prescribed medication? ☐ All the time ☐ Sometimes ☐ Never ☐ Other, explain if needed:	
Marital Status: ☐ Married ☐ Single/Never Married ☐ Divorced	Are you a Veteran? ☐ Yes ☐ No
Employment Status:	If working, average hours per week in last 30 days:
Volunteering? ☐ Yes ☐ No	If yes, average hours per week in last 30 days:
Currently enrolled in school? ☐ Yes ☐ No	If yes, average hours per week in school in last 30 days:
Highest education level completed:	Number of arrests in last 30 days:
Do you have children under age 18? ☐ Yes ☐ No	If yes, what ages: Do they reside with you? ☐ Yes ☐ No
Do your children have special needs? ☐ Yes ☐ No	Age you first received mental health services:
Have you received DBT services in the past? ☐ Yes ☐ No If yes, when and for how long?	
Have you been in an IRTS residential program in the past year? ☐ Yes ☐ No If yes, when?	
Have you utilized an IRTS crisis bed in the past year? ☐ Yes ☐ No If yes, when?	
Have you had any medical admissions to the hospital for self-harm injuries in the past year? ☐ Yes ☐ No If yes, when?	
Have you had any psychiatric hospital admissions in the past year? ☐ Yes ☐ No If yes, when?	
Have you had any emergency room visits for mental health issues in the past year? ☐ Yes ☐ No If yes, when?	
Have you attempted suicide in the past year? ☐ Yes ☐ No If yes, when?	
Have you engaged in non-suicidal self-injury in the past year? ☐ Yes ☐ No If yes, when?	

Other than those above, describe any other risky, impulsive behavior (e.g. impulsive sexual behaviors, gambling, alcohol, drugs, impulsive spending, binge eating, etc.):

Suicidal Ideation – within the past year, I have thought about killing myself: ☐ Never ☐ Sometimes ☐ A lot		
Please check the box if you experience difficulty in that area as a result of symptoms.		If yes, please give a brief description.
Utilizing mental health services	☐ Yes ☐ No	
Use of drugs and alcohol	☐ Yes ☐ No	
Educational, vocation and daily activity	☐ Yes ☐ No	
Social functioning	☐ Yes ☐ No	
Interpersonal relationships	☐ Yes ☐ No	
Self-care and independent living skills	☐ Yes ☐ No	
Medical or dental health	☐ Yes ☐ No	
Management of finances	☐ Yes ☐ No	
Housing	☐ Yes ☐ No	
Transportation	☐ Yes ☐ No	
Legal	☐ Yes ☐ No	
Other (e.g. sexuality, spiritual, parenting, cultural, etc.)	☐ Yes ☐ No	

Briefly describe your weekly commitments (full or part-time work, volunteer work, school, family/friend obligations, hobbies, etc.):
Briefly describe your primary concerns and the goals you would like to pursue with the help of our DBT program:
Briefly describe your current professional support network (doctors, psychiatrist, psychologist, therapist, support groups, etc.):
Please give us a sense of your schedule and availability. *Note that none of our therapists work on weekends.* Rank when you can come to skills group training: Monday PM Group (1-3:30 pm) Wednesday PM Group (2:30-5:00 pm) Tuesday AM Group (9:30-noon) Thursday PM Group (4:00-6:00 pm)
Describe your availability to come in for individual therapy (meet once a week for an hour):
Transportation – how will you get here? ☐ own car ☐ bus ☐ taxi ☐ medical transportation/ZIPS ☐ Other:
Do you have any parenting/childcare issues? Will you have child care set up for your children while attending skills group and individual therapy?

Do you have health insurance? ☐ Yes ☐ No	If yes, what type? Please include a copy of your insurance cards.