



RETREAT APPLICATION

PERSONAL INFORMATION (All personal information is treated confidentially. * Denotes required information)

Service Member/Veteran Name* _____ DOB* _____

Last 4 digits of SSN _____ Ethnicity _____ Tribal Affiliation? _____

What first name do you prefer to go by _____

Home Address* _____

City* _____ State* _____ Zip Code* _____

Email* _____ Cell Phone* _____

Marital Status* _____ Current Living Situation* _____

Do you have Children? _____ If so, how many? _____ Ages _____

Name of Emergency Contact* _____ Relationship* _____

Cell Phone* _____ Email _____

Have you attended any other retreat programs? Yes or No If yes, when/where _____

SERVICE INFORMATION

Branch of Service* _____ Service Years* _____ Discharge Date* _____ Discharge Type H/OTH

Combat Zone(s) _____ Deployment Dates _____

Name of MOS/AFSC _____

Current Status:* Active Duty Military Retired Veteran Other: _____ Rank:* _____

Is your Spouse/Partner a military veteran?* Yes No N/A

If yes, please provide the following:*

Branch of Service _____ Service Years _____ Discharge Date _____

Combat Zone(s) _____ Deployment Dates _____

Name of MOS/AFSC _____

Current Status: Active Duty Military Retired Veteran Other: _____ Rank: _____

POST TRAUMATIC STRESS (PTS) INFORMATION

If you have been diagnosed with PTS: Date/Year* _____

If at a VA facility, which one? _____

If not through the VA, by which Clinic or Professional Provider _____

Current/Past Counseling:* _____

Have you experienced Military Sexual Trauma? Yes No If yes, when and have you received any treatment _____

Has your Spouse/Partner been diagnosed with PTS? Yes No

PTS was diagnosed: Date/Year _____ What VA Facility? _____

If not the VA, what Clinic or Professional Provider? _____

Current/Past Counseling: _____

Has spouse/partner ever experienced (Military) Sexual Trauma? Yes No If yes, when _____

VETERAN PTS SYMPTOM QUESTIONNAIRE

Veteran Participant's Name* _____ Date* _____

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then check the box to the right to indicate how much you have been bothered by that problem in the past month. As a guide: Extremely might mean every day. Quite a Bit may mean 20 out of the last 30 days. Moderate may be 10 to 14 days. A Little Bit may be 10 days out of the month. If you have not been bothered by the described problem or complaint, mark Not At All.

	Response	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?					
2	Repeated, disturbing dreams of the stressful experience?					
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4	Feeling very upset when something reminded you of the stressful experience?					
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6	Avoiding memories, thoughts, or feelings related to the stressful experience?					
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or					
8	Trouble remembering important parts of the stressful experience (for some reason besides a head injury or alcohol or drug use)?					
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10	Blaming yourself or someone else (who didn't directly cause the event or actually harm you) for the stressful experience or what happened after it?					
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12	Loss of interest in activities that you used to enjoy?					
13	Feeling distant or cut off from other people?					
14	Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15	Feeling irritable or angry or acting aggressively?					
16	Taking too many risks or doing things that could cause you harm?					
17	Being "super alert" or watchful or on guard?					
18	Feeling jumpy or easily startled?					
19	Having difficulty concentrating?					

MEDICAL INFORMATION:

*Service connected disability % _____ Condition/Basis _____

*Prescription Medications and their uses (attach list if necessary):

*Do you have any lung or heart issues or a serious medical diagnosis?

*Unprescribed/illegal/recreational drugs, alcohol and/or tobacco use. What substance and how much/how often?

*If you are in recovery, how long? (All retreat participants must be free of any drug/alcohol addictions for at least 12 months prior to attending) _____

*Physical Conditions that require assistance/unique accommodations:

Are you an amputee? If so, which extremity(ies) and level(s) _____

Motorized Wheelchair Wheelchair Walker Cane Other: _____

*Medical Conditions: Diabetic Oxygen Nebulizer CPAP or other similar equipment. Other Medical

Conditions: _____

*Sensitivities or Allergies: Smoke Other: _____

Dietary: Vegetarian Vegan Gluten Free Other: _____

We will do our best to accommodate your dietary needs, but please let us know in advance if you require anything special. All meals are taken together in the main dining facility.

On occasion there are service dogs that attend the retreats. Do you have any issues being around dogs? Yes No

Comments: _____

*Do you have a Service Dog that is required because of a disability? Yes No

What work or task has the dog been trained to perform? _____

(Please note: "We welcome your well-behaved service animal. Please understand, however, that we cannot allow unruly dogs to disrupt our mission of providing services to our veterans. In the event your service dog misbehaves or becomes unruly, we will have no choice but to ask you to remove the dog from the premises/situation/room/etc.

GENERAL INFORMATION

Participants should arrive at the Guardian Hills Campus between the hours of 2:00 PM and 4:00 PM on the Sunday beginning the retreat. Travel will be paid by the participant. The Retreat does not cover any travel expenses. Retreat activities, lodging and meals will be provided at no cost to the participants. A list of recommended supplies, clothing, etc., as well as other detailed information will be forwarded to participants prior to the scheduled Retreat.

For questions related to the Retreats and/or the Retreat Application process, please call us at: 573-530-9292: or email: info@guardianhills.com. Once your application has been received and processed, you will be notified and placed in one of our first available scheduled retreats. See the Guardian Hills webpage (www.guardianhill.com) for retreat schedule. If circumstances require a particular retreat start date, please indicate below. **Availability is limited.**

Typically, there are 12 Retreats per year (2 per month May - October)

Please indicate your first(1) and second(2) choices of times to attend:

MAY() JUNE() JULY() AUGUST() SEPTEMBER() OCTOBER()

Once your application has been received, we will call you to discuss dates and details. Mail the entire completed Retreat Application to:

Guardian Hills Veterans Healing Center
Attn: Applications
1302 Morning Dove Drive
Columbia, MO 65201

[Email scanned applications to info@guardianhills.com](mailto:info@guardianhills.com)

****Please include a copy of your DD-214 with your application.**

How did you hear about Guardian Hills? _____

I have read the entire application and believe all of the answers given on the Retreat Application are true and correct.
I have also read the Center's health information privacy practices available online.

Signature of Service Member/Veteran*

Date *