Wilderness Treatment Center

200 Hubbart Dam Rd. Marion, MT 59925 (406) 854-2832 (406) 854-2835 fax
www.wildernesstreatmentcenter..com

Dear Family Member:

This letter and the enclosures that accompany it are to offer you specific information about our monthly family week. We believe that each patient will benefit in his treatment experience by his family's involvement and that the family will grow as well. We invite all family members to participate in our program, with the exception of those under the age of eight. If this age guideline poses a problem for you, please feel free to contact us to see if other arrangements can be made.

Some things that you as a family member can do in preparation for family week and also to aid in your own personal growth are to read the enclosed information, be involved in Alanon in your home area and also to detach from work responsibilities as much as possible while you are involved in the family week program. *Please do not use your cell phones while in the proximity of treatment buildings or patients.*

Our family program is scheduled the first week of every month. The date that the family program will be scheduled while your son is in treatment is _____. _____Our family program runs from Sunday morning at 9:00 through Thursday morning. The ROPES course activity will take place on Thursday morning.

Lodging and transportation is the responsibility of the family. We have enclosed information on car rental agencies and motels for your convenience. Please complete the form enclosed regarding accommodations and return it to us as soon as possible.

Sunday brunch and the noon meal will be provided at no cost to you during family week however you will need to make arrangements for breakfast and dinner on your own. Also please note: No pets allowed at the facility.

If we can be of any further help regarding any of this information, please feel free to contact us at any time. We look forward to your attendance at the family week and hearing from you in the future.

Sincerely,

WILDERNESS TREATMENT CENTER

Recovery Is The Best Alternative

Dear Family Member:

One important activity during the family week which the patients and family members participate in is the ROPES Course. This includes activities such as a *trust walk, a spider web,* a number of initiative games, and usually is capped off with the "*letting go*" exercise or The Wall. We have found the ROPES Course to be an important addition to our treatment program and an important method for building trust, learning group problem solving skills and new ways to communicate.

It is for these reasons that we are encouraging all family members to participate in our ROPES Course activities. Our family week program is held Sunday through Thursday morning. The ROPES Course activities will take place Thursday morning and will last half a day. These activities are not physically demanding and are informal. Please be sure to wear casual clothing for that day.

We look forward to meeting and spending time with you during this week.

Sincerely,

Wilderness Treatment Center

WILDERNESS TREATMENT CENTER

PLEASE COMPLETE THIS FORM AND MAIL IT BACK AS SOON AS POSSIBLE PRIOR TO THE BEGINNING OF FAMILY WEEK.

NAME: _____

PATIENT NAME: _____

DATES OF FAMILY WEEK: _____

NUMBER OF FAMILY MEMBERS ATTENDING: _____

ARRIVAL DATE: _____

DEPARTURE DATE: _____

ACCOMMODATIONS: _____

TRANSPORTATION ARRANGEMENT TO WTC THE FIRST MORNING: _____

_____
(You are responsible for your own transportation)

GIFTS – SNACKS

It is the philosophy of Wilderness Treatment Center to provide for a patient's needs – not necessarily their wants.

The Wilderness Treatment Center will make every effort to control the flow of goods to patients via parents, friends, relatives and visitors in general. Guilt often begets a continual flow of "gifts" to patients who are away from home. (Packages must be pre-approved before mailing. ***No packages from relatives and friends.***)

We ask that you not bring candy, snacks, etc. during family week or during treatment. (Items left here for patient may be locked up until they leave.)

FAMILY PROGRAM SCHEDULE

Sunday

8:45 a.m. – Check-In
9:00 a.m. – Introduction
10:00 - Brunch
11:00 – Alanon
12:00 – Disease Concept Lecture
1:30 – Step One
3:00 – Group
4:30 – Visitation
4:45 Depart Campus

Monday

8:45 – Check-In
9:00 – Alanon
9:45 – Family Systems/Roles Lecture
10:45 – Group
12:00 – Lunch
1:00 Video
1:30 – Group
4:00 – Video
4:45 Depart Campus

Tuesday

8:45 a.m. – Check-In
9:00 - Alanon
9:45 – Spirituality Lecture
10:30 – Group
12:00 – Lunch
1:30 – Knees to Knees
4:45 = Depart Campus

Wednesday

8:45 a.m. – Check-In
9:00 - Alanon
10:00 - Commitments Group
12:00 – Lunch
1:00 – Continuing Care Lecture
1:30 – Graduations
2:00 – Individual Family Conference
Depart campus after conference

Thursday

8:45 – Check-In
9:00 Challenge Course
12:00 Lunch
1:00 Depart Campus
End of Family Week

AREA HOTELS/MOTELS

Marion Area	Phone
At The Lake (Bed & Breakfast)	406-858-2456
Cabin Creek Landing (Bed & Breakfast)	406-854-2126
McGregor Lake Resort (Cabins)	406-858-2253
Little Bitterroot Lake Carriage House	406-854-2310
Hilltop Hitching Post (Small Highway Motel)	406-854-2442

Kalispell Area – Motels/Hotels	
Hampton Inn	406-755-7900
Red Lion	406-752-6660
Holiday Inn Express	406-755-7405
The Hilton Gardens	406-756-4500
Homewood Suites by Hilton	406-755-8080
Kalispell Grand Hotel	800-858-7433
La Quinta Inn & Suites	888-870-5552
The Outlaw Inn	406-755-6100
Motel 6	406-752-6355
Travel Lodge	406-755-6123
Super 8	406-755-1888
America's Best Value Inn	406-756-3222
Blue & White	406-755-4311
Comfort Inn	406-755-6700

Rental Cars	
Hertz	800-654-3131
Avis	800-331-1212
Budget Rent-A-Car	406-755-7500
Enterprise Rent-A-Car	406-755-4848
	800-325-8007

Kalispell Taxi & Airport Shuttle	406-752-4022

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FAMILY INFORMATION FORM

Date: _____

Patient's Information

First Name: _____Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Father's Information

Full Name: _____ ___ Living ____ Deceased

Address: _____City: _____

State: _____ Zip: _____

Phone Number: _____ Work Phone: _____

Fax: _____Cell Phone Number: _____

Email address: _____ Marital Status _____

Occupation: _____Education: _____

Employer: _____

Stepmother/Significant Other's Full Name (if applicable):_____

Mother's Information

Full Name: _____ ___ Living ____ Deceased

Address: _____City: _____

State: _____ Zip: _____

Phone Number: _____ Work Phone: _____

Fax: _____Cell Phone Number: _____

Email address: _____ Marital Status _____

Occupation: _____Education: _____

Employer: _____

Stepfather/Significant Other's Full Name (if applicable):_____

Guardian's Information (if applicable)

Full Name: _____ relationship to patient_____

Address: _____City: _____

State: _____ Zip: _____

Phone Number: _____ Work Phone: _____

Fax: _____Cell Phone Number: _____

Email address: _____ Marital Status _____

Occupation: _____Education: _____

Employer: _____

Are you currently receiving any counseling and/or psychotherapy? _____

Therapist Name: _____

Are you now, or have you ever been involved in any self-help, 12-step or recovery program?

_____

Is there a family history of Addiction/Alcoholism? _____Who, _____

Do you have a friend or relative who is in recovery from alcoholism or chemical dependency?

_____

Describe your understanding of addiction/alcoholism: _____

_____

Describe any religious/spiritual practices of the family: _____

_____

What has been the major problem area in your life in the past six months? _____

_____

Is there another major concern in your life right now, besides your child's chemical use?

_____

Is there a family member with whom your child has significant conflicts? _____

If yes, who _____

Describe attempts at discipline? _____

_____

Have any been successful? _____

_____

List people living in your household?

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Names and birthdates of children not living in household.

_____ _____

_____ _____

_____ _____

If spouse deceased, date of death: _____ Cause: _____

_____

Is your child adopted? _____When, at what age_____ any therapy related to this? _____

Are there any losses which have impacted your child? i.e. (death, grief, trauma, abuse) _____

_____

_____

List any medical conditions (cancer, diabetes, high blood pressure, etc.) of parent or blood relative and state relationship. _____

_____

Are you currently taking any medication? _____ If so, what? _____

Do you ever question your own drinking or other chemical use? _____

Do you ever question the use of alcohol or other drugs by someone in your family? _____

Who? _____

Describe son's using to the best of your ability

Substance	How often	Age	Last Use	How Much	How Used

Emotional/Mental Health
Has the patient been given a diagnosis by a qualified mental health professional?

Diagnosis	Date Given	Name of Professional

Patient Medical History

General health condition: Excellent: ____ Good____ Average____ Poor _____

Does the patient have any food restrictions? _____ Yes _____ No If yes, please explain:

_____

Allergies_____

List/Explain any Chronic conditions (asthma, heart murmur, diabetes, enuresis)

_____

History of surgeries/broken bones _____

Has patient ever been hospitalized other than for above described surgeries or fractures? If so, why and for how long? _____

_____

Medications
Name of Medication, Date Prescribed, Dosage/Schedule, Reason for Medication

Name of medication	Date prescribed	Dosage/Schedule	Reason for medication

Was he compliant with medications? _____

What are your beliefs about medications? _____

What is the problem with your son as you see it? _____

_____

Patient's Awareness of problem:

_____ No awareness. "No problem, I'm no worse than my friends. Everybody is doing it."

_____ Minimal awareness. "I can take it or leave it. I'm not too bad."

_____ Moderate awareness. "It's not my fault." "Sometimes I do get into trouble too much."

_____ Admits to problem. "I can't help it." "Something is bothering me."

_____ Well aware of the problem and accepts responsibility for change.

How long do you believe the problem has existed?

_____ Less than a year

_____ 1 – 3 years

_____ 3 – 6 years

_____6 – 10 years

Identify areas below impacted by his use:

_____ School problems

_____ Legal problems

_____ Health problems

_____ Emotional problems

_____ Peer relationship problems

_____ Family relationship problems

_____ Job/Occupational/Financial problems _____

_____ Cult or Gang related activities _____

Comments: _____

_____

To the best of your knowledge, has the patient ever experienced any of the following because of drug or alcohol use?

_____ Blackouts (a loss of memory without loss of consciousness; i.e. can't remember how he got home).

_____Alibis for drinking, i.e. ("All my friends drink.")

_____ Irresponsible; can't predict what they will say or do.

_____ Memory problems

_____ Changes eating habits

_____ Loss or changes in friends

_____ Personality change (describe) _____

To the best of your knowledge, what is the longest period the patient has been drug and alcohol free since the problem began?

_____ Absolutely don't know

_____ Probably uses each day

_____ Probably a few days at a time

_____ Probably weeks at a time

Why do you think your son has sought treatment at this time?

_____ Felt problem was serious and treatment was necessary

_____ To comply with someone else's wishes

_____ To avoid consequences of recent behavior

_____ To salvage school grades or job

What previous attempts at treatment have been tried for your son?

Place	Approx. date of Entry	Outcome
General Hospital	_____	_____
Alcoholism Treatment Center	_____	_____
Drug Treatment Center	_____	_____
Alcoholics Anonymous	_____	_____
Narcotics Anonymous	_____	_____
Psychiatric Treatment Center	_____	_____
Medical Treatment	_____	_____
Other _____	_____	_____

Describe anything else that you believe is relevant for the treatment of your son: _____

_____

_____