Personal Information	
Full Name:	
Phone:	Date of Birth:
Email:	
Address:	
City, Province:	Postal Code:
SIN:	PHN:

Referring Agent	
Name:	Agency:
Phone:	Address:

Emergency Contact	
Name:	Relationship:
Phone:	Address:

Source of Funding for Treatment Fees
☐ Self-funding ☐ Family ☐ Friend ☐ Other
Details:

Education / Work Experience		
☐ Grade School (K – 7)	☐ Some high school	☐ High school or GED
☐ Trade school	☐ Some college/university	☐ College/university degree
☐ Other		
What work experience do you have?		

Past Criminal Convictions	
Do you have a criminal record?	☐ Yes ☐ No
Please list your convictions:	
Do you have a history of sexual offences?	☐ Yes ☐ No
Do you have a history of violent crimes?	☐ Yes ☐ No

Current / Pending Criminal Charges	
Do you have pending civil, traffic or criminal cases?	☐ Yes ☐ No
Please list your charges:	
Court Location:	Court Date(s):

Legal Status	
Is treatment court-mandated?	☐ Yes ☐ No
Are you presently on probation?	☐ Yes ☐ No
Are you presently on parole?	☐ Yes ☐ No
If yes to any of the above, please list your conditions:	

Lawyer Contact		
Name:	Email:	
Phone:	Fax:	

Treatment History		
Have you previously received counselling for your addiction?	☐ No ☐ Yes	
Do you currently have an addictions counsellor?	☐ No ☐ Yes *(please provide details below)*	
Name:	Phone:	
Agency/Office:		
Have you previously attended substance abuse treatment program(s)?	☐ No ☐ Yes *(please complete the chart below)*	
Dates	*Program*	*Did you complete?*
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
Have you ever been asked to leave a program?	☐ No ☐ Yes	
If yes, please explain why:		

Last Substance Use
When was the last time you used any drug(s) or drank alcohol?
What did you use?

Substance Use History					
Substance	Method of Use *(e.g. smoke, snort, IV)*	Amount	Frequency	Age of First Use	Date Last Used
Alcohol					
Tobacco					
Marijuana					
Crack					

Substance Use History (Continued)					
Substance	Method of Use *(e.g. smoke, snort, IV)*	Amount	Frequency	Age of First Use	Date Last Used
Cocaine					
Crystal Meth					
Heroin					
Fentanyl					
Ecstasy					
GHB					
Illicit Methadone					
Inhalants					
Benzodiazepines					
Prescription drug abuse					
Other:					

Opiate Replacement Therapy	
Are you currently on an opiate replacement?	☐ No ☐ Yes *(please complete questions below)*
What are you taking?	☐ Methadone ☐ Suboxone ☐ Kadian ☐ Other:
How long have you been on opiate replacement therapy?	
What is your current dose?	
Who is the prescribing physician?	Physician's Phone:

Additional Challenges	
Have you ever struggled with any of the following?	
Sex Addiction ☐ No ☐ Yes	Grief & Loss ☐ No ☐ Yes
Problem Gambling ☐ No ☐ Yes	Other – please explain:

Family Background	
Do you have any sisters?	☐ No ☐ Yes *How many?*
Do you have any brothers?	☐ No ☐ Yes *How many?*
Are you adopted?	☐ No ☐ Yes
Did you spend time in foster care?	☐ No ☐ Yes
Are there any signs of alcoholism, heavy drinking, or substance abuse among your family members?	☐ No ☐ Yes
If yes, please explain:	

Relationship Status	
What is your current marital status?	☐ Single ☐ Married ☐ Common-Law ☐ Divorced ☐ Widowed ☐ Other:
How would you assess your current relationship?	☐ Good ☐ Indifferent ☐ Bad ☐ Other:

Family Status	
Do you have any daughters?	☐ No ☐ Yes *How many?*
Do you have any sons?	☐ No ☐ Yes *How many?*
Who is taking care of your child(ren) right now?	☐ Spouse / partner ☐ Family member ☐ Foster care ☐ Other:

Social Worker	
Name:	Phone:
Agency/Office:	

Medical Care Provider	
Do you currently have a doctor?	☐ No ☐ Yes *(please complete the chart below)*
Name:	Phone:
Agency/Office:	

Medical History		
Do you have any medical diagnoses?	☐ No ☐ Yes	
If yes, please list:		
Are you currently taking any medications?	☐ No ☐ Yes *(please complete the chart below)*	
Diagnosis	*Medication(s)*	*Dosage*
Have you been hospitalized in the last year?	☐ No ☐ Yes	
If yes, please explain why:		
Do you have any allergies?	☐ Food ☐ Drugs ☐ Environment ☐ Other:	
If yes, please provide details:		
Do you have any communicable diseases?	☐ TB ☐ HIV ☐ Hep A, B, or C ☐ Other:	
If yes, please provide details:		

Mental Health		
Do you have any psychiatric diagnoses?	☐ No ☐ Yes *(please complete questions below)*	
Please check all that apply:	☐ Depression ☐ Anxiety ☐ PTSD ☐ OCD	
Please list other psychiatric diagnoses:		
Are you currently taking any medications relating to your psychiatric health?	☐ No ☐ Yes *(please complete the chart below)*	
Diagnosis	*Medication(s)*	*Dosage*
Do you have a history of any of the following?	☐ Suicide attempts ☐ Self-harming behaviours ☐ Eating disorder(s) ☐ Fire-setting behaviours	
Have you ever been hospitalized for psychiatric care?	☐ No ☐ Yes	
If yes, please explain why:		
When was the date of your most recent hospital stay?		
Do you have any other comments about your mental health?		

Mental Health Care	
Do you currently have a mental health care worker, mental health team, or psychiatrist?	☐ No ☐ Yes *(please complete the chart below)*
If you do not have one, would you like to be connected with a Mental Health Worker?	☐ Yes ☐ No
Community Mental Health Worker / Team	
Name:	Phone:
Agency/Office:	
Psychiatrist	
Name:	Phone:
Agency/Office:	

Spiritual / Religious Beliefs	
Do you have any spiritual/religious beliefs?	☐ Yes ☐ No
If yes, what are they?	
Do you have an active devotional life or other spiritual practices?	☐ Yes ☐ No

Spiritual / Religious History	
Was your family an influence on your spiritual/religious life?	☐ Yes ☐ No
If yes, please explain:	
How would you describe your experience with spirituality/religion?	☐ Positive ☐ Negative
Do you see a connection between your spiritual/religious life and substance abuse?	☐ Yes ☐ No
If yes, please explain:	

Part 9: Program Readiness

Are you ready?
Is there anything that would prevent you from participating with community meals and/or household chores? ☐ No ☐ Yes
If yes, please explain:
Please list any challenges you've faced in the past, relating to your recovery:
What personal assets will aid you in your recovery?