



ALPHA HOUSE - APPLICATION FOR RESIDENCE

- Complete this application and submit via email, fax, or to the alphahousetoronto.ca website. In order for your application to be considered, you must attend our weekly Pre-Admission Group, each Monday from 10:30am to 12pm. If you are unable to attend, please call 416-469-1700 or email info@alphahousetoronto.ca to make alternate arrangements.
- If you are currently at an inpatient (residential) treatment centre, please ensure that you fill out and attach a Consent To Release Form with this application. This will ensure time-efficient communication with you during the application process. Your application will only be processed once we've received this document.

Please be advised that your application will not be placed on the waitlist until you have followed the above-named instructions.

Admissions Office
Alpha House Recovery Community
647 Broadview Avenue
Toronto, Ontario M4K 2N9
Tel: (416) 469-1700 Fax: (416)-469-0829
Email: info@alphahousetoronto.ca
Website: alphahousetoronto.ca

ALPHA HOUSE APPLICATION

CLIENT INFORMATION

Name:		Alias/ AKA:	
Today's Date:		DOB(dd/mm/yyyy):	
Health Card #:		Email:	
Cell Phone:		Home/Other Phone:	
Gender (I.E- Male, Female, Non- binary, bi-gender, intersex, other):			
Do you identify as Indigenous (status or non-status)? Yes / No			
Country of birth:			
Current address:			
City:		Province:	Postal:
Previous residence at Alpha: Yes / No		Date attended:	

EMPLOYMENT INFORMATION

What is your main source of income? Employment / OW / ODSP / Family Support / Savings / Other _____

If employed, please complete the following:

Current employer:		Address:				
Position/title:		Length of employment:				
List hours worked per week / Typical shifts						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

EMERGENCY CONTACT

Name of emergency contact:	
Address:	Phone:
Relationship to you:	

MARITAL STATUS

Are you: Single / Married / Common-law / Divorced / Separated / Other

Partner's name:	Partner's tel#
-----------------	----------------

EDUCATION

Highest level of education:

Degrees, Diplomas, Certificates:

REFERRING AGENCY

Agency Name	Contact Name	Phone

CHILDREN INFORMATION:

Name	Gender	Age	Nature of Contact

ALPHA HOUSE APPLICATION

LEGAL HISTORY

Are you currently involved in any legal matters? Yes / No
If Yes, please explain:

Do you have a criminal record? Yes / No

Convictions

Date / Sentence Served

Are you listed with the Ontario Sex offender Registry? Yes / No

Are you currently under a restraining order? Yes / No
Describe details:

History of Violence: Describe Incidents (Including Weapons)

MEDICAL HISTORY

Doctors Name:

Phone Number:

Address:

Date of last physical?

Do you have any major or chronic health problems? Yes / No
If Yes, please provide details:

Allergies? (Food, Animals, pollen, etc.)

Do you have any upcoming surgeries? Please Specify.

Do you have an Acquired Brain Injury or any history of brain trauma: Yes / No
If Yes, please provide details:.

ALPHA HOUSE APPLICATION

List any other Physical injuries or disabilities:

Any history of seizures? Yes / No
 If yes, when and how frequently? Were they alcohol-related?:

Please list **all current medications** below:

Medication	Dosage	Purpose	On medication Since

Have you stopped taking any medications in the last 6 months? Yes / No
 If so, Please list the medications, reason why you stopped taking the medication and if this decision was approved by your physician.

MENTAL HEALTH INFORMATION

Have you ever been diagnosed with a mental health disorder? Yes / No

Diagnosis	When	By Whom

Are you currently receiving professional help to manage your mental health? Yes / No

Do you believe you may have a mental health issue that has not been diagnosed? Yes / No
 Explain:

Have you ever been hospitalized for mental health? Yes / No
 Date of last hospitalization and description of the events.

ALPHA HOUSE APPLICATION

Have you ever attempted suicide? Yes / No
 Explain (When, How many times, last attempt)

Do you currently have thoughts of suicide or self-harm?

Psychiatrist Name:

Phone Number:

SUSTANCE USE HISTORY

Psychoactive Drug History Questionnaire

Drug Type	Used in Last 12 Months	Frequency of use. (ex. daily, binge, 2 times per week, etc.)	Last day of Use	Route of administration (I.E – smoke, snort, I.V.)
None				
Methadone /Suboxone	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cocaine/Crack:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Amphetamines:Crystal Meth/ Speed/Ritalin/ Other Stimulants/ Benzedrine/ Dexedrine	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cannabis: hash/ weed/marijuana/oil	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Benzodiazepines: Valium/Ativan/Clonazepam/Librium/etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Barbiturates : (Phenobarbital, Seconal, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Heroin/opium	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescription Opioids: Fentanyl / Dilaudid/Demerol/ Percocet/etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Alcohol/ Beer / Liquor	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Over the counter codeine reparations: (T1/T3/ Cough medications, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Hallucinogens: LSD/DMT/STP/PCP/Magic Mushrooms)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Glue/Gasoline other inhalants	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Tobacco: (cigarettes, cigars, chew, snuff etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other Psychoactive drugs.	<input type="checkbox"/> Yes <input type="checkbox"/> No			

ALPHA HOUSE APPLICATION

PREVIOUS ADDICTIONS TREATMENT HISTORY

Where	When	Length of stay

Have you ever been discharged from a treatment center for cause? If So, Please explain:

Have you ever attended or are you currently attending Self-help groups? (IE: 12-step groups, Smart Recovery, Dharma Punx, Rational Recovery, Etc.) Yes / No

Give a brief description of your history and involvement in Self-help groups:
(E.g. Home group, Sponsor, leadership role, Previous Issues)

What is the longest duration of abstinence you have previously obtained?

SIGNATURE

I _____, state that all information in this document I have entered is true to the best of knowledge at this time.

Signature of applicant:

Date: