Client Demographic Survey

This survey and information is totally confidential. It is an anonymous survey; no name is required on this form.

Please check the boxes that applies to you:

1. **Age Group:**
   ☐ 18 – 24 ☐ 25 – 40 ☐ 41 – 64 ☐ 65 and over
2. **Gender:**
   ☐ Female ☐ Transgendered ☐ Non-Binary ☐ I prefer not to say
3. **Housing Status:**
   ☐ Shelter ☐ Respite/Drop-in ☐ Homeless ☐ Subsidized Housing
   ☐ Rooming House ☐ Transitional Housing ☐ Market rent ☐ Living with family/friends
4. **Source of Income:**
   ☐ Ontario Works (OW) ☐ Ontario Disability Support Program (ODPS)
   ☐ No Income ☐ Employment Insurance (EI) ☐ OAS/CPP
   ☐ Workplace Safety and Insurance Board (WSIB) ☐ Employment (Full-time/Part-time)
   ☐ Other _____
5. **Do you self-identify as a member of a designated group (s).**
   ☐ Aboriginal ☐ New Immigrants and Refugees ☐ Veteran ☐ LGBTQ2S
   ☐ Person with disabilities ☐ Francophone ☐ Visible minority ☐ Newcomer
6. **Involvement with the law**
   ☐ Probation ☐ Parole ☐ Bail ☐ No involvement ☐ Other
7. **How did hear about this program?**
   ☐ Online ☐ Word of mouth ☐ Doctor ☐ Social/Community agency_____(name)
   ☐ Street Haven ☐ Shelter ☐ Healthcare professional ☐ Housing ☐ Treatment
   ☐ Probation/parole ☐ Other
8. **Level of education**

☐ Elementary ☐ Secondary ☐ Post-secondary ☐ GED

Thank you for your kind cooperation.

STREET HAVEN ADDICTION SERVICES

TREATMENT PROGRAM APPLICATION

Legal Name: _____ Date: _____

Preferred Name: _____

Date of birth: (dd/mm/yy) _____

Health card Number: _____

Contact information:

Address: _____

_____

Phone: _____ Okay to call? ❑ Yes ❑ no

Email Address: _____

Please describe your current living arrangements. _____

_____

Family/Marital status:

❑ Married/Common law ❑ Single (never married)
❑ Widow ❑ Divorced/Separated

Do you have children? ❑ Yes ❑ no

Do you have contact with them? ❑ Yes ❑no

Has there been C/CAS or Native Child and Family Services involvement?

❑ Yes ❑ no which children? _____

Do you need to arrange childcare while you are in treatment? ❑ Yes ❑ no

LANGUAGE AND ETHNOHISTORY

What language(s) do you speak? _____

What is your country of origin? _____

What ethnic/cultural group do you identify with? _____

Are there any resources/accommodations you may require to assist in practice/communication? If so please describe_____
_____

EMPLOYMENT/INCOME

Are you employed ❑ yes ❑ no

If yes, please provide details: _____

What is your source of income? _____

SUBSTANCE USE HISTORY

When was your last use? _____

When did your substance use become a dependency? _____

_____

What is your substance of choice?

1st: _____

2nd: _____

3rd: _____

How often did you use in the past 30 days?

❑ Did not use
❑ 1 to 3 times a week
❑ 3 to 6 times a week
❑ daily

Please indicate any substances you have used in the past year:

❑ Alcohol	❑ Heroin	❑ Hallucinogens (K)
❑ Crack	❑ Opium	❑ Ecstasy
❑ Cannabis	❑ Amphetamines (Ritalin)	❑ Prescription opioids (oxys, percocets, Fentanyl, Dilaudid)
❑ Cocaine	❑ Barbiturates	❑ Crystal meth
❑ Glue/Inhalants	❑ Benzodiazepines (Valium)	❑ GHB

Injection drug use:

- ❑ Never injected
- ❑ Injected more than one year ago
- ❑ Injected in the past 12 months

Have you ever been to treatment before? If so, please fill in the following chart:

Name of treatment program	Year attended	Program length	Length of sobriety post treatment

Describe your current support network_____

What are your recovery goals? Abstinence? Supported care?

_____

LEGAL INFORMATION (if applicable)

Do you have any charges, fines or warrants outstanding or pending?

_____

Do you have any upcoming court dates?

_____

Are you currently on probation/parole?

_____

If yes please list your probation/parole officer's contact information:

_____

Please list conditions_____

If in custody, have you been sentenced? ❑ Yes ❑ no

If yes, when is your sentencing date? _____

HEALTH INFORMATION

Do you have a family doctor? ❑ Yes ❑ no

If yes, please list their contact information below

_____

Are you currently pregnant? ❑ Yes ❑ no

If yes, when is your due date? _____

Have you ever experienced withdrawal seizures? _____

Do you have any significant health concerns at the moment? Do you require daily medication?

_____

In the past year, have you been to an emergency room? ❑ Yes ❑ no

If yes, please provide more information:

_____

_____

Have you **ever** had a psychiatric diagnosis?

_____

_____

Have you ever experienced suicidal thoughts or ideations? _____

Are you currently on methadone or suboxone ❑ yes ❑ no?

What is your dosage? _____

Please list any other medications you are currently taking:

_____

_____

Are you capable of walking up and down stairs several times a day? ❑ Yes ❑ no

Are you capable of daily outings in the community? ❑ Yes ❑ no

Are you capable of performing regular household duties? ❑ Yes ❑ no

How did you hear about our program?

❑ Detox ❑ Doctor ❑ Family
❑ Friend ❑ Internet ❑ Nurse
❑ P.O. officer ❑ Self-help group (AA CA) ❑ Community worker
❑ Corrections social worker
❑ Addictions day program
❑ Other _____

I certify that all information provided above is true, complete and curate to the best of my ability.

☐ I confirm that the information given in this form is true, complete and accurate.

The information contained in these documents is confidential, privileged and only for the information of the intended recipient and may not be used, published or redistributed without the prior written consent of the information provider.

Please note this intake form does not guarantee you a treatment bed. A worker will be in touch with you to complete an assessment within 1-2 weeks of your submission.

PLEASE FAX COMPLETED INTAKE FORM TO 647-360-4222 OR EMAIL IT TO:
ADDICTIONSERVICES@STREETHAVEN.COM

Signed_____

Date: _____

****Attached consent form is for the purpose of adopting a more comprehensive and integrated approach to treatment and maintaining a continuity of care. It is required by law for Street Haven to connect with outside service providers regarding shared information pertaining to client care.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate upon client discharge from service,

Please complete if you wish to have Street Haven staff connect with any relevant supports and/or service providers.

Street Haven Addiction Services

Consent to Disclose Personal Information

I, _____,
(Print your name)

Authorize _____

To disclose information consisting of:

- ❑ clinical records
- ❑ physical health information
- ❑ mental health information
- ❑ Children's Aid Society
- ❑ treatment plans
- ❑ OW/ODSP
- ❑ discharge summary
- ❑ psychiatric evaluation
- ❑ Legal (conditions)

To Street Haven Addiction Services staff – Grant House

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my care and maintaining a continuity of care for this purpose only unless otherwise permitted or required by law.
This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of clinical treatment.

I understand the purpose for disclosing this information to Grant House staff. I understand I can refuse to sign this consent form.

Print name: _____

Signature: _____ Date: _____

Witness name: _____

Signature: _____ Date:_____

Street Haven Addiction Services
Phone: 416 967 6060 **Ext** 327 **Fax:** 647 360 4222
Street Haven Addiction Services – Grant House site
144 Roxborough Street West, Toronto, ON , M5R 1V1