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? How often did you use in the past 30 days?

1st: __________________

□ Did not use

□ 1 to 3 times a week

□ 3 to 6 times a week

□ daily

2nd: __________________

□ 1 to 3 times a week

□ 3 to 6 times a week

□ daily

3rd: __________________

□ 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:

<table>
<thead>
<tr>
<th>Name of treatment program</th>
<th>Year attended</th>
<th>Program length</th>
<th>Length of sobriety post treatment</th>
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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 accurate 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 416-920-3380 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.
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: 416 960 9430 Fax: 416 920 3380
Street Haven Addiction Services – Grant House site
144 Roxborough Street West, Toronto, ON, M5R 1V1