



## 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:**

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Heroin	<input type="checkbox"/> Hallucinogens (K)
<input type="checkbox"/> Crack	<input type="checkbox"/> Opium	<input type="checkbox"/> Ecstasy
<input type="checkbox"/> Cannabis	<input type="checkbox"/> Amphetamines (Ritalin)	<input type="checkbox"/> Prescription opioids (oxys, percocets, Fentanyl, Dilaudid)
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Crystal meth
<input type="checkbox"/> Glue/Inhalants	<input type="checkbox"/> Benzodiazepines (Valium)	<input type="checkbox"/> 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 416-920-3380 OR EMAIL IT TO:  
[ADDICTIONSERVICES@STREETHAVEN.COM](mailto: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:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> clinical records            | <input type="checkbox"/> Children's Aid Society | <input type="checkbox"/> discharge summary      |
| <input type="checkbox"/> physical health information | <input type="checkbox"/> treatment plans        | <input type="checkbox"/> psychiatric evaluation |
| <input type="checkbox"/> mental health information   | <input type="checkbox"/> OW/ODSP                | <input type="checkbox"/> 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