



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. Pronouns:

- She/her He/Him They/them Other

4. Housing Status:

- Shelter Respite/Drop-in Homeless Subsidized Housing
 Rooming House Transitional Housing Market rent Living with family/friends

5. 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 _____

6. Do you self-identify as a member of a designated group (s).

- Indigenous New Immigrants and Refugees Veteran LGBTQ2S
 Person with disabilities Francophone Visible minority Newcomer

7. Involvement with the law

- Probation Parole Bail No involvement Other

8. 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

9. Level of education

- Elementary Secondary Post-secondary GED



STREET HAVEN ADDICTION SERVICES

TREATMENT PROGRAM APPLICATION

Legal Name: _____ Date: _____

Preferred Name: _____ Preferred Pronouns _____

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

Age: _____ 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: _____

2nd: _____

3rd: _____

- 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

What is your Covid-19 vaccination status? _____

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?

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.