STREET HAVEN ADDICTION SERVICES

TREATMENT PROGRAM APPLICATION

Legal Name: _____ Date: _____

Preferred Name: _____

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

Age: ____

Contact information:

Address: _____

_____

Phone: _____ Okay to call? ❑ Yes ❑ no

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 was your first 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 you 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?

_____

Please list conditions_____

HEALTH INFORMATION

Do you have a family doctor? ❑ Yes ❑ no

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? _____

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.

CLIENT DEMOGRAPHIC SURVEY

Date:_____
month/year

Please check the boxes that apply to you

Age Group

☐ 16-24 ☐ 25-40 ☐ 41-64 ☐ 65 and over

Gender

☐ Female ☐ Trans ☐ Other _____

Source of Income

☐ Ontario Works (OW)
☐ Spouse/Family
☐ Private Disability Insurance
☐ Employment (Part time/Full time)
☐ Other _____
☐ Ontario Disability Support Program (ODSP)
☐ Old Age Security/Canadian Pension Plan (OAS/CPP)
☐ Employment Insurance (EI)
☐ No Source Of Income

Housing

☐ Shelter ☐ Respite/Drop-in ☐ Supportive Housing ☐ Transitional Housing
☐ Rooming House ☐ Subsidized Housing ☐ Subsidized Housing Waiting List
☐ In-Residence Treatment ☐ Half-Way House ☐ Temporary Housing (staying with friend)
☐ Other _____

Education

☐ Elementary ☐ Secondary ☐ Post Secondary ☐ GED

Involvement with the Law

☐ Probation ☐ Parole ☐ Other ☐ No Involvement

Member of Designated Group

☐ Indigenous ☐ Newcomer ☐ Refugee ☐ LGBTQ2S ☐ Visible Minority
☐ Person with Disability ☐ Francophone ☐ Veteran

Do you have experience with:

☐ Chronic Disease ☐ Mental Health ☐ HIV/HepC ☐ Trauma ☐ Addiction

How did you hear about Street Haven?

☐ Internet ☐ Word of Mouth ☐ Health/Community Agency, name_____ ☐ Other _____

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: _____