



STREET HAVEN ADDICTION SERVICES

TREATMENT PROGRAM APPLICATION

Legal Name: _____ Date: _____

Preferred Name: _____

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

Age: _____ Health card Number: _____

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 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 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 _____

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

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? _____

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?

- | | | |
|--|--|---|
| <input type="checkbox"/> Detox | <input type="checkbox"/> Doctor | <input type="checkbox"/> Family |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Internet | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> P.O. officer | <input type="checkbox"/> Self-help group (AA CA) | <input type="checkbox"/> Community worker |
| <input type="checkbox"/> Corrections social worker | | |
| <input type="checkbox"/> Addictions day program | | |
| <input type="checkbox"/> 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.



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: 416 960 9430 Fax: 416 920 3380
Street Haven Addiction Services – Grant House site
144 Roxborough Street West, Toronto, ON , M5R 1V1

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

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

Indegenous 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 _____ Other _____
name