Admission Prescreening

Date of Assessment:		Approved by Nurse Practitioner/CEO Please highlight once this document has been approved.
Name of Assessor:		Length of Assessment:
Client Information		
Last Name:		First Name:
Address:		
Gender:		Level of Education:
Preferred Pronouns:		D.O.B:
Weight:	Height:	Email:
Phone Number:		Voicemails OK? ☐ Yes ☐ No
Referral Source: Phone Number:		Email:
Funding Source: ☐ AB ☐ SK ☐ Private Pay		Occupation:
Allergies/Food Sensitivities:		
PHN:		
General Practitioner:		☐ Records Requested
Community Supports:		☐ Records Requested
Goals for Treatment:		
Reason for Treatment:		

Admission Prescreening

Suicidal Ideation:
History of suicide attempts:
Most Recent Suicide attempt:
History of Self-Harming Behaviour:
Most recent incident of self-harm:
Homicidal Ideation:
History of Violence or aggression:
Any Gang affiliated markings or tattoos: ☐ Yes ☐ No
Criminal Record: ☐ Yes ☐ No ☐ Probation ☐ Parole
Additional Information (Any trouble with the law - when, please explain):

Admission Prescreening

Medical Concerns or Conditions:		
Medications:		
Psychiatric Diagnosis' or History of Psychiatric concerns:		
Any Formal Diagnosis:		
Substance Use:		
Substance	**Amount**	**Last Use**
Withdrawal Symptoms (Current or history):		

Admission Prescreening

History of Eating Disorder:
Previous Treatment History:
Emergency Contact information
Name:
Relationship to client:
Phone:
Email:

Admission Prescreening

Additional Comments from admissions department:

Admission Prescreening

Additional Comments from Medical Team and/or CEO or Designate: