Admission Prescreening

For Thorpe Recovery Centre Use Only	
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 Name: **Email:** **Phone Number:**	
AB Health Card Number:	**Source of income:**
Medication Coverage (please provide as shown on card): **Treaty Number:**	
Allergies/Food Sensitivities:	
General Practitioner:	☐ Records Requested
Community Supports:	☐ Records Requested
Goals for Treatment:	
Reason for Treatment:	

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Suicidal Ideation:
History of suicide attempts:
Most Recent Suicide attempt:
History of Self-Harming Behavior:
Most recent incident of self-harm:
Thoughts of harming others either current or past:
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):

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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):		

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

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Additional Comments from admissions department:

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