Applicant Information

GENERAL INFORMATION

Legal Name: _____
Last First Middle

Preferred Name: _____ Alias: _____

Address: _____
PO Box/Suite Street Address City Province Postal Code

Phone Number: _____ Alternate Number: _____

Email Address: _____

Gender: ☐ Agender ☐ Female ☐ Gender Fluid ☐ Intersex ☐ Male ☐ Non-Binary ☐ Questioning
☐ Transgender Male ☐ Transgender Female ☐ Two-Spirit ☐ Prefer not to Disclose
☐ Not Listed: _____

Ethnicity: _____ Indigenous: ☐ No ☐ Yes: Status #: _____

Date of Birth: (YYYY/MM/DD) _____ Current Age: _____

Provincial Health Number: _____ Province: _____

Medical Benefits # *(if applicable)* _____ Carrier #: _____

Group or Plan # _____ Certificate / Member #: _____

How did you hear about the Thorpe Recovery Centre? _____

Do you have any relationships – personal or otherwise, with any TRC staff? ☐ No ☐ Yes: _____

EMERGENCY & SUBSTITUTE DECISION MAKER CONTACT INFORMATION

Emergency Contact:

Name: _____ Relationship: _____

Address: _____
PO Box/Suite Street Address City Province Postal Code

Phone Number: _____ Alternate Number: _____

Email Address: _____

2nd Emergency Contact:

Name: _____ Relationship: _____

Address: _____
PO Box/Suite Street Address City Province Postal Code

Phone Number: _____ Alternate Number: _____

Email Address: _____

REFERRAL SOURCE INFORMATION

☐ Self/Family ☐ AHS Addiction & Mental Health ☐ SK Addiction & Mental Health ☐ Child Welfare

☐ Physician/Hospital ☐ Other Community Mental Health & Addiction Support

☐ Employer/ EAP ☐ Legal/Justice System/Drug Court ☐ Other: _____

Referral Source Name: _____ Agency: _____

Phone: _____ Fax: _____

Email: _____

INCOME & EDUCATION

Income Source: ☐ Employed ☐ Alberta Works ☐ AISH ☐ EI ☐ On-Reserve Income Assistance
☐ Other Assistance ☐ Other source of income ☐ No income
☐ No income, performing unpaid work (caregiver, parenting) ☐ SIS ☐ SAID

Length of Current Status _____ Occupation _____

What is your highest level of completed education? ☐ Gr. 1 – 9 ☐ Gr. 10 – 12 ☐ Some Post-Secondary
☐ Post- Secondary ☐ ☐ Trade Certificate

Do you have a learning disability? ☐ ADHD ☐ Comprehension ☐ Processing Deficits
☐ Reading ☐ Non-Verbal ☐ Writing ☐ Other: _____

FAMILY AND SOCIAL HISTORY

What is your partnership status? ☐ Married/ Common Law ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Do you have any concerns regarding your relationships or non-relationships? *Please explain:*

_____

_____

Do you have children? ☐ No ☐ Yes (*please list, attach additional pages if necessary):*

Name	Age	Sex	Does this Child Live With You?
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

Do you have any concerns regarding your relationship with your children? Please describe your concerns

_____

Please list all of your support systems (i.e. 12 step, family, friends, church, community agencies etc.)

_____

HOUSING

Do you have a permanent residence? ☐ No ☐ Yes:

With whom are you now living with _____ *for how long?* _____

Do you currently live with anyone who has a substance use disorder? ☐ No ☐ Yes

ADDICTION HISTORY

Please list substances used (past and present) including drugs, alcohol, solvents, prescriptions, over the counter medications, and behaviours. Use an * to indicate your primary addiction and ** for your secondary: *Attach additional pages if required*

Substance	Amount Used	Daily/Weekly/Monthly	Date of Last Use	Age of First Use	Considered Problematic?

What are your withdrawal symptoms?_____

Have you ever been hospitalized for drug induced psychosis or alcohol withdrawal? ☐ No ☐ Yes

Have you ever been affected by the alcohol/drug use, gambling and/or process addictions of family members?

☐ No ☐ Yes *(describe)*: _____

GAMBLING & GAMING HISTORY

Which types of gambling (past and present) have you participated in?

☐ VLT ☐ Pro-line ☐ Track ☐ Bingo ☐ Casino ☐ Virtual Gaming

☐ Online Poker ☐ Card Games ☐ Games of Skill ☐ Lotteries ☐ Other: _____

How long have you been playing the above game(s) and how often do you gamble? _____

How long have you recognized gambling as problem? _____

What are your main concerns about your gambling at this time? _____

OTHER HISTORY

Do you identify any of these behaviours as being problematic? ☐ Internet Use ☐ Relationships ☐ Shopping ☐ Sex ☐ Food ☐ Other: _____

If you checked yes for food, would you describe it as an eating disorder? ☐ No ☐ Yes *(explain):*

_____

TOBACCO USE

Do you currently use tobacco or nicotine products? If yes, complete the following:

Do you currently smoke cigarettes? ☐ No ☐ Yes

Do you currently use an e-cigarette/vape? ☐ No ☐ Yes

Do you currently chew tobacco? ☐ No ☐ Yes

TREATMENT AND DETOX

Is this your first time accessing any form of treatment? ☐ No ☐ Yes

Have you previously accessed or received treatment at Thorpe Recovery Centre? ☐ No ☐ Yes

Date(s) _____ *Did you complete the program?* ☐ No ☐ Yes

Have you previously attended detox/or residential programming at another centre? ☐ No ☐ Yes

If yes, where? _____ *When?* _____

Did you complete? ☐ No ☐ Yes *Reason*: _____

TRAUMA/LOSS

Have you experienced any of the following types of abuse/trauma?

☐ Sexual Abuse ☐ Physical Abuse ☐ Emotional Abuse ☐ Domestic Violence ☐ Other: _____

Have you experienced any of the following types of significant life losses?

☐ Death ☐ Health Problem/Change ☐ Divorce/Separation ☐ Loss of Job/School

☐ Other: _____

Are you experiencing any of the following concerns?

☐ Problems with Family ☐ Housing Problems ☐ Problem with Social Environment

☐ Financial Problems ☐ Educational Problems ☐ Problem with Access to Health Care

☐ Occupational Problems ☐ Legal Problems ☐ Other: _____

LEGAL HISTORY

Do you have any of the following issues: ☐ Parole** ☐ Probation** ☐ Bail**

☐ Incarceration (Including Remand) ☐ House arrest

☐ Conditional Sentence ☐ Non-Contact Order

☐ Child & Family Orders

Do you have any past charges? ☐ No ☐ Yes (*explain*): _____

_____

Do you have any outstanding legal charges? ☐ No ☐ Yes (*explain*):

Charge(s): _____

Upcoming court date(s): _____

Do you have any other legal issues? ☐ No ☐ Yes (*explain*): _____

**Probation Officer or Bail Supervisor Name: _____

Phone Number: _____ Email: _____

Legal Counsel: _____

Firm: _____ Phone Number: _____

MEDICAL HISTORY

Primary Physician: _____

Address: _____

PO Box/Suite Street Address City Province Postal Code

Office Phone: _____ Office Fax: _____

Have you had any medical conditions/illnesses within the past two years? ☐ No ☐ Yes *If yes, identify:*

Known allergies (environmental, food, medication, etc.): ☐ No ☐ Yes (*describe*):

Do you have any special dietary requirements (cultural or intolerances)? ☐ No ☐ Yes (*describe*):

Do you have any issues that require accommodation? (hearing loss, mobility etc.) ☐ No ☐ Yes (*describe*):

Do you have trouble with sleeping?: ☐ Apnea ☐ Staying Asleep ☐ Falling Asleep ☐ Night Terrors ☐ Snoring ☐ Sleepwalking

Are you affected by any of the following?: ☐ HIV/AIDS ☐ Hepatitis ☐ Scabies ☐ Lice ☐ Bed Bugs

PSYCHOLOGICAL AND MENTAL HEALTH INFORMATION

Are you currently seeing a mental health professional? ☐ No ☐ Yes *(specify):*

☐ Psychiatrist ☐ Psychologist ☐ Therapist ☐ Other: _____

Name: _____ City: _____

Phone: _____ Email: _____

Do you have a current formal mental health diagnosis? ☐ No ☐ Yes *(specify):*

When, and by whom? _____

☐ ADD/ADHD ☐ Anxiety Disorder ☐ Bipolar ☐ Borderline Personality Disorder
☐ Depression ☐ Dissociative Disorder ☐ FASD ☐ OCD ☐ PTSD
☐ Schizophrenia ☐ Substance Use Disorder ☐ Other: _____

Do you have a past mental health diagnosis? ☐ No ☐ Yes *(specify):*

When, and by whom? _____

If yes, please check all that apply:

☐ ADD/ADHD ☐ Anxiety Disorder ☐ Bipolar ☐ Borderline Personality Disorder
☐ Depression ☐ Dissociative Disorder ☐ FASD ☐ OCD ☐ PTSD
☐ Schizophrenia ☐ Other: _____

Medication	Start Date	Dosage	Reason

Have you had any suicidal thoughts or attempts in the past year? ☐ No ☐ Yes *(specify):*

When: _____ *What happened:* _____

Do you currently have any suicidal thoughts or are planning an attempt? ☐ No ☐ Yes*(specify):*

What is your plan: _____

With Who: _____

What is your plan: _____

Do you have any history of self-harm behaviours? ☐ No ☐ Yes *(specify):*

Have you received or inquired for help with this? ☐ No ☐ Yes *(specify):*

GOALS

What are your goals for treatment?

This Applicant Information was completed by:

☐ Self- Referral (includes Family Members)

☐ Referral

Referral Source Name: _____ Agency: _____

Phone: _____ Fax: _____

Email: _____