

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?
			<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> 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: _____

Phone: _____

Email: _____

Agency: _____

Fax: _____