Applicant Information ☐Detox Only ☐Residential

GENERAL INFORMATION

Legal Name:_____
Last First Middle

Preferred Name:_____ Alias:_____

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

Phone Number:_____ Alternate:_____

Email Address:_____

Gender: ☐Agender ☐Female ☐Gender Fluid ☐Intersex ☐Male ☐Non Binary
☐Questioning ☐Transgender Female ☐Transgender Male ☐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 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

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

☐Employer EAP ☐Legal/Justice System/ Drug Court

☐Child Welfare ☐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:

_____

HOUSING

Do you have a permanent residence? ☐No ☐Yes

With whom are you 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 If alcohol, specify daily or binge dinking	Date of Last Use	Age of First Use	Considered Problematic

Have you ever used carfentanyl or fentanyl? ☐No ☐Yes If yes, when? _____

What are your current withdrawal symptoms, if any? _____

What was your past withdrawal experience like?_____

Do you have a history of overdose? ☐No ☐Yes

Have you had a previous seizure? ☐No ☐Yes If yes, where? (home, hospital, etc.)_____

History of delirium tremors or ICU admission due to withdrawal ☐No ☐Yes

Any previous benzodiazepine use? ☐No ☐Yes

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

Are you currently pregnant ☐No ☐Yes

Have you ever been affected by alcohol/drug use, gambling/process addictions of family members? ☐No ☐Yes

GAMBLING & GAMING HISTORY

☐No ☐Yes (describe):_____

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

☐VLT ☐ Pro_line ☐Track ☐Bingo ☐Casino ☐Virtual Gaming Community Mental

☐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 you main concerns about your gambling at this time? _____

TOBACCO USE

Do you currently use tobacco or nicotine products? If yes, complete the following:	☐No	☐Yes
Do you 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 if Job/School

☐Other :_____

Are you experiencing any of the following concerns?

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

☐ Financial Problems ☐ Education 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*** ☐ Conditional Sentence
☐ Incarceration (including remand) ☐ House Arrest
☐ Child & Family Orders

Please list any no contact orders if any:_____

Do you have any past charges? ☐No ☐Yes
(If yes, please explain):_____

Do you have any outstanding legal charges? ☐No ☐Yes
(If yes, please explain):_____

Upcoming court date(s):_____

Do you have any other legal issues? ☐No ☐Yes
(If yes, please 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: _____
_____

Do any of the following conditions apply: History of kidney or liver failure, pulmonary failure (ex: COPD) and complex conditions. ☐No ☐Yes If yes, please explain:

_____
_____

Known Allergies (environmental, food, medication, ect.) ☐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?

When, and by whom?_____

☐ 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: _____

Do you have a 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:_____