All Required (RED) Sections Must Be Filled Out

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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:_________________________

Email Address:____

Gender:

Ethnicity:____________________ Indigenous : 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? If Yes, Please List Staff Names:

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:____

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REFERRAL SOURCE INFORMATION

Referral Source Name:_______________________________ Agency_____________________________________

Phone: ____ Fax: _______________________________________

Email:____

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? 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?

Have you had a previous seizure? If yes, where? (home, hospital, etc.)_____________________

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Delirium Tremens is the most severe form of alcohol withdrawal and is a medical emergency. It is characterized by profound confusion. It may also include agitation, disorientation, hallucinations, fever, high blood pressure, sweating, high pulse and even cardiovascular collapse. It is usually treated in Intensive Care Units.

Type Initials

I HAVE READ THE ABOVE DESCRIPTION PRIOR TO ANSWER THE FOLLOWING QUESTIONS

1) Have you ever had delirium tremens?

   If yes,

   When?

   Where was it treated?

   How long did it last?

2) Have you ever been admitted to a hospital due to alcohol or drug withdrawal?

   If yes,

   When?

   Where was it treated?

   How long did it last?

3) Have you ever been admitted to an Intensive Care Unit due to alcohol or drug withdrawal?

   If yes,

   When

   Where was it treated?

   For how long?

Drug-induced psychosis happens when you experience episodes of psychosis, such as delusions or hallucinations, as a direct result of substance abuse.

Type Initials

I HAVE READ THE ABOVE DESCRIPTION PRIOR TO ANSWER THE FOLLOWING QUESTIONS

1) Have you experienced drug-induced psychosis?

   If yes,

   When?

   Where was it treated?

   How long did it last?

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A seizure is a sudden, uncontrolled burst of electrical activity in the brain. It can cause changes in behaviour, movements, feelings, and levels of consciousness. It often results in convulsions.

Type Initials

I HAVE READ THE ABOVE DESCRIPTION PRIOR TO ANSWER THE FOLLOWING QUESTIONS

1) Have you ever had a seizure?

   If yes,

   When?

   Where did it happen?

   How long did it last?

Benzodiazepines are commonly used medications that produce sedation, relieve anxiety, and reduce seizures. Commonly used benzodiazepines include Ativan, Valium, Restoril, Clonazepam, Xanax.

Type Initials

I HAVE READ THE ABOVE DESCRIPTION PRIOR TO ANSWER THE FOLLOWING QUESTIONS

1) Have you ever used benzodiazepines?

   If yes,

   When did you start taking them?

   How often do you use them?

Are you currently pregnant

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

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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? If yes, identify:

____

____

Do any of the following conditions apply: History of kidney or liver failure, pulmonary failure (ex: COPD) and complex conditions If yes, please explain:

____

____

Known Allergies (environmental, food, medication, ect.) *(If yes please describe):*

____

____

Do you have any special dietary requirements (cultural or Intolerances)? *(If yes please describe):*

____

____

Do you have any issues that require accommodation? (hearing loss, mobility etc.) *(If yes please describe):*

____

____

Do you have trouble with sleeping?
Select Up To 3 If Necessary

Some sleeping conditions may include:
- Apnea
- Night Terrors
- Staying Asleep
- Falling Asleep
- Snoring
- Sleepwalking

Are you affected by any of the following
Select Up To 3 If Necessary

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PSYCHOLOGICAL AND MENTAL HEALTH INFORMATION

Are you currently seeing a mental health professional

Name:____City____

Phone: _________________________________Email:____

Do you have a current formal mental health diagnosis?

If Other, Specifiy: ____

Do you have a past mental health diagnosis?

If Other, Specifiy: ____

Medication	Dosage	Reason

Have you had any suicidal thoughts or attempts in the past year? If yes, please specify below:

When: ____

What happened: ____

Do you currently have any suicidal thoughts or are planning an attempt? If yes, please specify below:

What is your plan:____

With who: ____

Do you have a history of self-harm behaviours? If yes, please specify below:

____

Have you received or inquired for help with this? If yes, please specify below:

Please Specify____

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INCOME & EDUCATION

Income Source:

Length of Current Status_________________________ Occupation _____________________________________

What is your highest level of completed Education

Do you have a learning disability?
Select Up To 3 If Necessary

FAMILY AND SOCIAL HISTORY

What is your partnership status?

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

____

____

Do you have children? (please list, attach additional pages if necessary)

Name	Age	Sex	Does this Child Live With You

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

____

HOUSING

Do you have a permanent residence?

With whom are you living with ____________________________________ for how long?______________

Do you currently live with anyone who has a substance use disorder?

GAMBLING & GAMING HISTORY

(describe):____

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

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

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How long have you recognized gambling as problem? ____

What are you main concerns about your gambling at this time? ____

DISORDERED EATING

Have you ever been diagnosed with an eating disorder?

Do you often think about food, weight, and body image?

Do you use food to cope with emotions and stressful situations?

SEX LOVE & RELATIONSHIPS

Have you ever engaged in sexual activities to cope with emotions and stressful situations?

Do you ever feel out of control with your sexual behaviors or relationship patterns?

Have you had any negative consequences because of compulsive

sexual/relationship behaviors?

TOBACCO USE

Do you smoke cigarettes?

Do you currently use an e-cigarette/vape?

Do you currently chew tobacco?

TREATMENT AND DETOX

Is this your first time accessing any form of treatment?

Have you previously accessed or received treatment at Thorpe Recovery Centre?

Date(s)______________________ Did you complete the program?

Have you previously attended detox/or residential programming at another centre?

If yes, where? _________________ When? _______________

Did you complete? Reason:______________________

TRAUMA/LOSS

Have you experienced any of the following types of abuse/trauma? Select As Many As Needed

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

Are you experiencing any of the following concerns?

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LEGAL HISTORY If you are on conditions you must provide a copy with application.

Do you have any of the following issues:

Please list any no contact orders if any:____

Do you have any past charges?

(If yes, please explain):____

Do you have any outstanding legal charges?

(If yes, please explain):____

Upcoming court date(s):____

Do you have any other legal issues?

(If yes, please explain):____

***Probation Officer or Bail Supervisor Name:____

Phone Number:_____________________________Email:____

Legal Counsel:____

Firm: ____Phone Number:__________________________________

GOALS

What are your goals for treatment at the Thorpe Recovery Centre?

____
____
____
____
____
____
____
____
____
____

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