Hope House Trauma & Addiction Support Centre

Counseling Intake Form

RULES:

Thank you for your interest in *Hope House Barrie Trauma and Addiction Support Centre*.

Prior to submitting your application, we require you to read the following program policies. In order to be admitted into this program, these policies must be agreed to by you.

1. Clients are expected to attend all scheduled activities including, but not limited to: classes, one- on-one counseling, group sessions, and all supplementary programming. Initial _____

2. Clients may be asked at any time in the program to provide a urinalysis or a medical check-up. Clients will provide a urinalysis during the intake process. Initial _____

3. Clients displaying a poor attitude towards program, aggressive or violent behaviour, or disregard for the rules, may be discharged. This includes violence of any kind (verbal or physical) to any participant or staff in the building. Initial _____

4. If placed on the wait-list, I will check-in with the *Hope House* or *Hope Centre* office once per week. Initial _____

I admit that I have an addiction and/or trauma and request that I be accepted into *Hope House Barrie* for the sole purpose of dealing with addiction and/or trauma. I have read the above outlined description of the program and I am willing to abide by all program rules and meet all program expectations and to actively participate in all aspects of the program. I understand that failure to do so will result in my being asked to leave the program.

CLIENT NAME: _____

SIGNATURE: _____

DATE: _____

WITNESS: _____

DATE: _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION:

I hereby authorize *Hope House Barrie* to release and/or obtain information from the following agencies/persons listed below:

_____

I recognize that information may be shared, as required, with other team members and programs within *Hope Barrie*. In addition, confidential information will be shared without written consent if child abuse is suspected, records are subpoenaed, or clients are felt to be a threat to their own or another individual's health and/or safety.

I hereby waive any and all claims against *Hope House Barrie*, employees and agents for all purposes whatsoever arising from the disclosure of this information.

CLIENT NAME: _____

SIGNATURE: _____ DATE: _____

STAFF SIGNATURE: _____ DATE: _____

ASSESSMENT DATE: _____

☐ ACCEPTED ☐ DELAYED INTAKE ☐ REFERRED ☐ DENIED

ASSESSMENT NOTES (OFFICE STAFF ONLY):

GENERAL INFORMATION:

FULL NAME: _____

DATE OF BIRTH: _____ GENDER: ☐ MALE ☐ FEMALE

CELL PHONE NUMBER: _____

HOME PHONE NUMBER: _____

ADDRESS: _____

_____

_____

EMAIL: _____

RELATIONSHIP STATUS: ☐ NEVER LEGALLY MARRIED ☐ LEGALLY MARRIED
☐ SEPARATED, BUT STILL LEGALLY MARRIED
☐ DIVORCED ☐ WIDOWED

DO YOU HAVE CHILDREN? ☐ YES ☐ NO HOW MANY? _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO YOU: _____

EMERGENCY CONTACT PHONE: _____

ONTARIO WORKS / ODSP WORKER: _____

LEGAL INFORMATION:

ARE YOU INVOLVED WITH FAMILY CONNEXIONS (formerly Children's Aid Society)?

CAS WORKER: _____

DO YOU HAVE VISITATION SCHEDULE WITH YOUR CHILDREN? _____

HAS C.A.S. REQUIRED YOU TO GO TO TREATMENT? _____

HAVE YOU EVER BEEN ARRESTED? _____

PLEASE LIST ALL PENDING CHARGES: _____

_____

_____

PLEASE LIST ALL PAST CHARGES: _____

_____

_____

UPCOMING COURT DATES: _____

DO YOU HAVE A NO CONTACT ORDER AGAINST ANYONE, OR DOES ANYONE HAVE A NO CONTACT ORDER AGAINST YOU? IF SO, WHO? _____

_____

HAVE YOU EVER HAD ANY GANG AFFILIATIONS? PAST OR CURRENT. _____

ARE YOU ON PROBATION OR PAROLE? _____

PROBATION / PAROLE OFFICER NAME: _____

PROBATION / PAROLE OFFICER PHONE: _____

LAWYER: _____ PHONE: _____

DRUG / ALCOHOL HISTORY:

ARE YOU CURRENTLY IN DETOX? ☐ YES ☐ NO

ARE YOU CURRENTLY IN ANOTHER TREATMENT PROGRAMME? ☐ YES ☐ NO

HAVE YOU EVER ATTENDED A FAITH-BASED PROGRAMME? ☐ YES ☐ NO

HAVE YOU EVER BEEN TO:

AA? ☐ YES ☐ NO

NA? ☐ YES ☐ NO

CR? ☐ YES ☐ NO

OR ANOTHER 12-STEP PROGRAMME? ☐ YES ☐ NO

HAVE YOU EVER COMPLETED DETOX OR ANOTHER PROGRAMME? ☐ YES ☐ NO

WHERE AND WHEN? _____

_____

_____

FIRST DRUG OF CHOICE: _____

SECOND DRUG OF CHOICE: _____

THIRD DRUG OF CHOICE: _____

LAST TIME YOU USED: _____

DO YOU HAVE ISSUES WITH GAMBLING? ☐ YES ☐ NO

WHY DO YOU WANT TREATMENT NOW? _____

_____

_____

MEDICAL INFORMATION:

DO YOU CURRENTLY HAVE A FAMILY DOCTOR? ☐ YES ☐ NO

NAME OF FAMILY DOCTOR: _____

ADDRESS: _____

PHONE NUMBER: _____

LIST ALL CURRENT MEDICATION: _____

_____

_____

_____

DESCRIBE ANY MEDICAL CONCERNS (INCLUDING ANY ILLNESSES &/OR MEDICAL CONDITIONS THAT YOU HAVE): _____

_____

_____

ANY SEVERE ALLERGIES REQUIRING AN EPI-PEN? ☐ YES ☐ NO

IF YES, WHAT ARE THEY AND DATE OF DIAGNOSIS?

_____

_____

CURRENT BLOOD PRESSURE: _____/_____

MENTAL HEALTH:

HAVE YOU BEEN DIAGNOSED / TREATED FOR MENTAL HEALTH? ☐ YES ☐ NO

LIST DIAGNOSIS / CONCERNS: _____

_____

_____

_____

HAVE YOU THOUGHT OF SUICIDE AS A WAY OUT RECENTLY (LAST 2 WEEKS)?

☐ YES ☐ NO

HAVE YOU EVER TRIED TO COMMIT SUICIDE? ☐ YES ☐ NO

IF YES, WHEN? _____

MENTAL HEALTH WORKER / PSYCHIATRIST: _____

PHONE: _____

ANY OTHER INFORMATION:

MEDICAL ASSESSMENT / MENTAL HEALTH NOTES (OFFICE STAFF ONLY):