Tamarack Recovery Centre

Intake Assessment Form

TAMARACKRECOVERY CENTRE
60 Balmoral Street, Winnipeg, Manitoba, R3C 1X4
Intake: 204-775-3546, Fax: 204-772-9908
info@tamarackrecovery.org

Tamarack Recovery Centre

OUR VISION

Healthy people, free from addiction.

OUR MISSION

To provide a safe, welcoming environment where individuals are supported in recovery to realize their full potential.

OUR VALUES

Our values are based on a dedication and commitment to:

Safety

Creating a warm, welcoming environment where the safety and care of all is key.

Integrity

Holding ourselves to the highest standards of personal and professional integrity, reflected in our ongoing commitment to ethical practice and serving as an example to all.

Respect

Recognizing and valuing diversity, being responsive to personal recovery needs and treating all people as unique individuals deserving of the best care.

Excellence

Using our knowledge and experience to deliver the highest quality services and seek out opportunities to improve and excel.

Compassion

Inspiring hope through our belief in the fundamental value of every human being, their resilience and ability to change.

TAMARACK RECOVERY CENTRE INTAKE ASSESSMENT FORM

The purpose of this questionnaire is to obtain information that will help determine whether Tamarack Recovery Centre is a program that will contribute to your recovery process. Completing this form as fully and accurately as possible will expedite the process of assessing your suitability for the program at Tamarack. Please be assured that all information you provide will be kept confidential, in accordance with the legal and ethical guidelines of the Canadian Association of Social Workers (CASW).

PLEASE PRINT YOUR ANSWERS. If you need additional space, please use the note section on page 8. If you require assistance completing this form, please telephone our Intake Specialist at 204-775-3546.

Date:_____

Name of Applicant:_____

Name of Person Completing this Form: _____

Relationship to Applicant: _____

APPLICANT INFORMATION

Male _____ Female _____

Last Name _____ First Name _____

Home Address _____

City_____ Province_____ Postal Code _____

Telephone Number(s)	**Message OK?**
Home _____	**Y / N**
Cell_____	**Y / N**
Other_____	**Y / N**

Date of Birth_____ Aboriginal Status Treaty #_____

Relationship Status (circle one) Single Married Common-Law Separated Divorced Widowed

We reserve the right to terminate a client's stay immediately if the information on the application form is later found to be deliberately incorrect or new information emerges that has been deliberately withheld.

Applicant's signature_____Date_____

DEPENDENT CHILDREN	Please provide the following information:			
Name	Male / Female	Date of Birth	Resides with:	Custody Status / CFS Involvement

EMPLOYMENT STATUS / INCOME SOURCE

Please tick one and complete as required.

- ☐ ***Full Time*** Occupation_____ Employer _____
- ☐ ***Part Time*** Occupation_____ Employer _____
- ☐ Correctional Facility _____
- ☐ EIA
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Unemployed – Employment Insurance
- ☐ Sick Leave – Employment Insurance
- ☐ Retired
- ☐ Homemaker
- ☐ Student at _____ Program_____

REFERRAL SOURCE

Please tick and complete.

☐ Self

☐ Other _____

(Name and Organization)

How did you / they hear about Tamarack?

(phonebook; website; radio; newspaper; organization; family member)_____

_____

CONTACT INFORMATION

In order to provide the best service possible, it may be necessary to contact the following people. Please provide names and contact information for the people/professionals that are involved in your life. All personal information will be kept confidential in accordance with the legal and ethical guidelines of CASW, and will not be communicated to sources outside Tamarack without your written consent.

Emergency Contact

Name _____

Relationship _____

Address _____

Home Phone _____

Other Phone _____

Other Agencies / Professionals (e.g. EIA Worker)

Name _____

Address _____

Phone _____

Fax_____

Family Physician

Name _____

Address _____

Phone _____

Fax_____

Psychiatrist

Name _____

Address _____

Phone _____

Fax_____

Psychologist/Therapist

Name _____

Address _____

Phone _____

Fax_____

Parole Officer

Name _____

Address _____

Phone _____

Fax_____

MEDICAL INFORMATION

Do you have Hep C? (please circle) Yes No MHSC#_____
Do you have HIV? (please circle) Yes No PHIN# _____
Do you have TB? (please circle) Yes No

Do you currently have any other ***physical health*** concerns or major illnesses for which you may be receiving medical treatment? Please describe:

_____
_____
_____
_____

Do you currently have any ***mental health*** concerns for which you may be receiving medical treatment? Please describe:

_____
_____
_____
_____

Do you have a mental health (psychiatric) diagnosis? (please circle) **Yes** **No** **Don't Know**
If yes, what is the diagnosis? Diagnosis One_____
Diagnosis Two_____

Have you been hospitalized previously for mental health reasons? (please circle) **Yes** **No**
If yes, number of times? _____
Reasons for hospitalizations?

_____
_____
_____

In the past have you made plans to complete suicide? (please circle) **Yes** **No**

Have you attempted suicide in the past? (please circle) **Yes** **No**

If yes, how many times? ___. When was the last time that you attempted suicide? _____

Has self-harm, such as cutting, been a concern for you in the past? (please circle) **Yes** **No**

Is self-harm, such as cutting, a concern for you in the present? (please circle) **Yes** **No**

Are you currently or have you previously received therapy to deal with specific issues in your life? (please circle) **Yes** **No**

If yes, please complete the following by circling **Yes** or **No**:

Individual Therapy	**Yes**	**No**
Group Therapy	**Yes**	**No**
Couple's Therapy	**Yes**	**No**
Family Therapy	**Yes**	**No**

Do you currently have or have you had an eating disorder or disordered eating behaviour?
(please circle) **Yes** **No**

If **yes** please describe (Examples: Controlled or restriction of food, Binging or overeating, purging through vomiting or excessive exercise).

_____
_____
_____
_____
_____
_____

MEDICATION

Are you currently taking prescription medication for physical or mental health reasons? **Yes** **No**
If yes, please provide the following information for the medication you have been prescribed:

Medication	Dosage	Time(s) Taken	Purpose

DRUG/TREATMENT HISTORY

What are the current circumstances that have motivated your decision to apply to Tamarack Recovery Centre?

_____
_____
_____

What is your drug of choice? _____ Date last used? _____
Please list other drugs used_____
_____

Have you ever used injection drugs**?** **Yes** No If Y**es**, date last used**:** _____
Age first used Alcohol/Drugs_____

What Withdrawal Symptoms have you experienced? _____

Have you ever overdosed? **Yes** **No** On which substance did you overdose? _____

PREVIOUS TREATMENT PROGRAMS ATTENDED

Name	Date	Complete program?	What did you gain?

Are Self-Help Groups part of your Recovery Plan? (please circle) **Yes** **No**
Please explain why or why not_____
_____
Name of Home Group?_____
Do you have a sponsor? **Yes** **No** If no, do you plan on getting a sponsor? **Yes** **No**

LEGAL

List Current Charges	Details_____ _____
Criminal/ Civil Charges Pending **Yes** **No**	Details _____ _____
Outstanding Warrants **Yes** **No**	Details _____ _____
Bail (probations) Conditions **Yes** **No**	Details _____ _____
Restraining Orders **Yes** **No**	Details _____ _____
Court Hearing Dates **Yes** **No**	Details _____ _____

List Previous Charges	Date of Charge

PERSONAL GOALS

What goals would you like to achieve by coming to Tamarack?_____
_____
_____
_____
_____

Please identify 3 personal shortcomings:
1._____
2._____
3._____

Who have been the main supports in your life?_____
_____
_____

Is there any additional information you would like us to know? _____
_____
_____

ADDITIONAL NOTES

Please use this section if you require extra space when completing this form.