



Intake Assessment Form

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



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 _____

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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.

<input type="checkbox"/>	Full Time Occupation _____ Employer _____
<input type="checkbox"/>	Part Time Occupation _____ Employer _____
<input type="checkbox"/>	Correctional Facility _____
<input type="checkbox"/>	EIA
<input type="checkbox"/>	Short Term Disability
<input type="checkbox"/>	Long Term Disability
<input type="checkbox"/>	Unemployed – Employment Insurance
<input type="checkbox"/>	Sick Leave – Employment Insurance
<input type="checkbox"/>	Retired
<input type="checkbox"/>	Homemaker
<input type="checkbox"/>	Student at _____ Program _____

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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 One _____
diagnosis? 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 **Yes**, 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? _____ _____

