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

Last Name ___________________________________ First Name _________________________________

Home Address ____

City__________________________Province_________ Postal Code_______________________

Home Phone:______________________ Message OK? Y / N MHSC#______________________________
Cell Phone:_______________________ Message OK? Y / N PHIN# _______________________________
Other: ___________________________ Message OK? Y/ N

Date of Birth: _____________________ Age: ________________

Sex Assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say

What gender do you identify as? ☐ Woman ☐ Man ☐ Non-binary/ third gender
☐ Prefer to self-describe ______________________________ ☐ Prefer not to say

Preferred Pronoun: ☐ He ☐ She ☐ They ☐ Ze ☐ A pronoun not listed ☐ No pronoun preference

REFERRAL SOURCE

	Self
	Other (Name and Organization) ____________________________________

How did you/they hear about Tamarack? (website; radio; newspaper; organization; family member)
____
____

	EMPLOYMENT STATUS / INCOME SOURCE			Please tick and complete.
	Employed Full–Time: Employer____			
	Employed Part-Time: Employer ____			
	Correctional Facility: ____			
	EIA		Retired	
	Short-Term Disability		Work at Home	
	Long-Term Disability		Student at (program) ___________________________	
	Employment Insurance -EI		Volunteer/Service Work at: _____________________	

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

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____
Last Visit (approx. date) _______________________

Family Physician
Name ____
Address ______________________________________
Phone _______________________________________
Fax____
Last Visit (approx. date) _______________________

Psychiatrist
Name ____
Address ______________________________________
Phone _______________________________________
Fax____
Last Visit (approx. date) _______________________

Psychologist/Therapist/Mental Health Worker
Name ____
Address ______________________________________
Phone _______________________________________
Fax____
Last Visit (approx. date) _______________________

Parole Officer
Name ____
Address ______________________________________
Phone _______________________________________
Fax____
Last Visit (approx. date) _______________________

MEDICAL INFORMATION

Do you have Hep C? (please circle) Yes No
Do you have HIV? (please circle) Yes No

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 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____

Date of diagnose(s):

Name of attending Physician/Psychiatrist:

Do we have your permission to contact your Physician/Psychiatrist? (please circle) **Yes** **No**

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/ have you previously received therapy to deal with specific issues in your life? **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? **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**

ADDICTION/TREATMENT HISTORY

What are the current circumstances that have motivated you 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____

How frequently do you typically use substances? ____

When do you typically use substances? ____

____

What Withdrawal Symptoms have you experienced when you have tried to stop using? ___________________

____

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

What other addictive behaviours do you currently struggle or have you struggled with? (tick all that apply)

	Gambling/Gaming		Spending		Internet
	Food		Sex		Relationships
	Other: ________________________________				

PREVIOUS TREATMENT PROGRAMS ATTENDED

Name	Date	Complete program?	What did you gain?

Are Self-Help Groups (e.g. AA/CA/ Refuge for Recovery/ SOS/ SMART) 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**	
Bail (probations) Conditions **Yes** **No**	
Restraining Orders **Yes** **No**	
Court Hearing Dates **Yes** **No**	

List previous Charges:	Date of Charge:

PERSONAL GOALS

What goals would you like to achieve by coming to Tamarack?________________________________
____
____
____
____
____

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.

Please note: We reserve the right to terminate a client's stay 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_________________**