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.

This publication and all others related to your treatment are available in alternate formats on request. Please contact our Intake Specialist at 204-775-3546 who will be happy to help.

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**_____