

Education:	<input type="checkbox"/> No Formal Schooling	<input type="checkbox"/> Some Primary School	<input type="checkbox"/> Primary School
	<input type="checkbox"/> Some Secondary School	<input type="checkbox"/> Secondary School	<input type="checkbox"/> High School Completed
	<input type="checkbox"/> Some College/University	<input type="checkbox"/> College/University	<input type="checkbox"/> Post Graduate
Current Income Source(s): (Please check applicable boxes):			
<input type="checkbox"/> Wages or Salary	<input type="checkbox"/> Disability Pension	<input type="checkbox"/> Retirement Pension	<input type="checkbox"/> GWA <input type="checkbox"/> WCB
<input type="checkbox"/> Employment Insurance (EI)	<input type="checkbox"/> FBA	<input type="checkbox"/> No Sources	<input type="checkbox"/> Other (Specify):

SUBSTANCE ABUSE ISSUES

Substance(s) Used in Last 30 Days - (In order of severity):

1 st Substance:	Severity Code:	Severity Code: Fill blanks with the following codes. 01 = Did not use; 02 = 1 to 3 times per week; 03 = 4 to 6 times per week; 04 = daily use; 05 = binge
2 nd Substance:	Severity Code:	
3 rd Substance:	Severity Code:	

Substances Used in the Last 12 Months – (Please check appropriate boxes):

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Heroin/Opium	<input type="checkbox"/> Steroids
<input type="checkbox"/> Amphetamines (Stimulants)	<input type="checkbox"/> Crack	<input type="checkbox"/> Methamphetamines (Crystal Meth)	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> None	<input type="checkbox"/> Unknown
<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Glue/Inhalants	<input type="checkbox"/> Over the Counter Codeine	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Cannabis	<input type="checkbox"/> Hallucinogens	<input type="checkbox"/> Prescription Opioids	<input type="checkbox"/> Other (Specify):

Is there a history of substance abuse in your family (Specify):

GAMBLING ISSUES

Do you have a gambling problem?: Yes No

<input type="checkbox"/> Bingo	<input type="checkbox"/> Non Casino Card Table Games	<input type="checkbox"/> Internet Gambling	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Slot Machines	<input type="checkbox"/> Sports Betting	<input type="checkbox"/> Stock Market/Real Estate	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Gaming Machine	<input type="checkbox"/> Lottery Tickets	<input type="checkbox"/> Games of Skill	<input type="checkbox"/> None
<input type="checkbox"/> Casino Card Table Games	<input type="checkbox"/> Instant Win/Scratch	<input type="checkbox"/> Outcome of Events	<input type="checkbox"/> Unknown

HEALTH RELATED ISSUES

Please check any known personal health issues or concerns:

<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> STD
<input type="checkbox"/> Mobility	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Stomach/Gastrointestinal
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lice/Scabies	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> None

Is there any medical condition you feel we should be aware of: Yes No

If Yes above, please explain:

Intravenous Drug Use (IDU):

<input type="checkbox"/> Never Used	<input type="checkbox"/> In the past 12 Months	<input type="checkbox"/> Prior to 12 Months
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Number of overnight hospitalizations in the last 12 months for physical problems:			
Have you ever been diagnosed with a mental health problem by a qualified mental health professional?:			
Within last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No		Within lifetime: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospitalized for a mental health problem?:			
Within last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No		Within lifetime: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever received treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?:			
Currently: <input type="checkbox"/> Yes <input type="checkbox"/> No		Within last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Within lifetime: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Service Provider:			
Medications that you are currently taking for ANY condition:			
Name of Medication:	Reason Prescribed:	Dosage/Frequency:	Prescribing Doctor's Name:
		/	
		/	
		/	
		/	
		/	
Are you currently on a Methadone Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			

TREATMENT HISTORY			
Have you attended a Drug/Alcohol Treatment Program: <input type="checkbox"/> Yes <input type="checkbox"/> No			If YES, please complete the following
Name of Centre:	Date Attended:	Length of Stay:	Completed: Yes/No; if No give reason
Have you been a resident of a Recovery Home Program: <input type="checkbox"/> Yes <input type="checkbox"/> No			If YES, please complete the following
Name of Recovery Home:	Date Attended:	Length of Stay:	Reason for Discharge:
Have you ever attended outpatient counseling for addiction: <input type="checkbox"/> Yes <input type="checkbox"/> No			If YES, please complete the following
Name of Agency:	Date Attended:	# of Sessions:	Outcome of Therapy:

PERSONAL GOALS & OBJECTIVES

How do you feel the Ken Brown Recovery Home can assist you in your recovery?:

Please describe three (3) specific goals/objectives which you would like to accomplish during your stay?:

1.

2.

3.

APPLICANT DECLARATION

The above information is true to the best of my knowledge. If accepted, I will participate fully in the Ken Brown Recovery Programs

Client/Guardian signature

Date

FOR OFFICE USE ONLY

Today's Date:

Chart/File #:

Admission Status:

Waitlist Status:

Please forward application to:

EXECUTIVE DIRECTOR
KEN BROWN RECOVERY HOME
8 Herrick Street
Sault Ste. Marie, Ontario
P6A 2T4
FAX # (705) 942 3472