The Salvation Army
Addictions & Residential Centre

Transformations

Intake Form - *Client*

CLIENT IDENTIFICATION

Name _____ DOB _____
(Last) *(First)* *(Middle)*

Address _____
(Apt/Street Number) *(City and Province)* *(Postal Code)*

Phone # _____ _____ SIN: _____
(Home) *(Cell)*

CLIENT INFORMATION

AB Health # _____ AISH File # _____

Income Support File # _____

Are you indigenous? ☐ Yes ☐ No Membership Nation _____

Do you have Status? ☐ Yes ☐ No Status Card # _____

Do you Receive Financial assistance for a Psychological Disability?

Do you Receive Financial assistance for a Medical Disability?

Name financial assistance provider and details: _____

_____

Education Level Attained _____

EMERGENCY CONTACT INFORMATION

Primary Contact _____ Relationship _____
(Name)

Phone # _____ _____ _____
(Home) *(Work)* *(Cell)*

CONSENT FOR RELEASE OF INFORMATION

I, _____ of _____
(Print Name) *(City/Town)*

Authorize The Salvation Army Transformations Program to obtain or release information contained in this Intake Application for the purpose of sharing information with other health professionals, agencies, or institutions involved in the Assessment/Placement/Treatment process.

Applicant Signature _____ (Date) _____
(yyyy.mm.dd)

Witness Signature _____ (Date) _____
(yyyy.mm.dd)

RISK ISSUES

1. Current Suicide Ideation ☐ Yes ☐ No When? _____ *(yyyy.mm.dd)*

Details _____

_____

_____

2. Previous Suicide Attempt ☐ Yes ☐ No When? _____ *(yyyy.mm.dd)*

Details _____

_____

_____

3. Previous Suicide Ideation ☐ Yes ☐ No When? _____ *(yyyy.mm.dd)*

Details _____

_____

_____

4. Deliberate Harm to Self ☐ Yes ☐ No When? _____ *(yyyy.mm.dd)*

Details _____

_____

_____

5. Violent Behaviour ☐ Yes ☐ No When? _____ *(yyyy.mm.dd)*

Details _____

_____

_____

6. Fire Setting/Damage ☐ Yes ☐ No When? _____ *(yyyy.mm.dd)*

Details _____

_____

_____

7. Sex Offender ☐ Yes ☐ No When? _____ *(yyyy.mm.dd)*

Details _____

_____

_____

CURRENT SYMPTOM CHECKLIST

Rate intensity of symptoms currently present

None - Symptom not present at this time

Mild - Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate - Significant impact on quality of life and/or day-to-day functioning

Severe - Profound impact on quality of life and/or day-to-day functioning

	None	*Mild*	*Moderate*	*Severe*
substance abuse				
self-mutilation				
aggressive behaviors				
irritability				
violent temper				
conduct problems				
oppositional behavior				
agitation				
depressed mood				
poor grooming/hygiene				
poor concentration				
guilt				
sleep disturbance				
hyperactivity				
fatigue/low energy				
mood swings				
emotional trauma victim				
physical trauma victim				
sexual trauma victim				
appetite disturbance				
laxative/diuretic abuse				
elevated mood				
anorexia				
paranoid ideation				
dissociative states				
somatic complaints				
delusions				
hallucinations				
emotionality				
generalized anxiety				
panic attacks				
hopelessness				
phobias				
social isolation				
worthlessness				
other (specify)				

SUBSTANCE ABUSE HISTORY

			Onset Age	*How Much (Peak)*	*How Often (Peak)*	*Last Use*
Tobacco	☐ Yes	☐ No				
Alcohol	☐ Yes	☐ No				
Caffeine	☐ Yes	☐ No				
Marijuana	☐ Yes	☐ No				
Cocaine	☐ Yes	☐ No				
Crack	☐ Yes	☐ No				
Amphetamines	☐ Yes	☐ No				
Barbiturates/downers	☐ Yes	☐ No				
Heroin	☐ Yes	☐ No				
Pain killers	☐ Yes	☐ No				
Methadone	☐ Yes	☐ No				
Meth	☐ Yes	☐ No				
Tranquilizers	☐ Yes	☐ No				
Sleeping pills	☐ Yes	☐ No				
Hallucinogens (LSD)	☐ Yes	☐ No				
PCP	☐ Yes	☐ No				
Stimulants	☐ Yes	☐ No				
Inhalants (glue, gas)	☐ Yes	☐ No				
Ecstasy	☐ Yes	☐ No				
Fentanyl	☐ Yes	☐ No				
Other (list)	☐ Yes	☐ No				

Have you ever used drugs intravenously? ☐ Yes ☐ No _____

Consequences of Substance Abuse *(Check all that apply)*		
hangovers	☐ Yes	☐ No
withdrawal symptoms	☐ Yes	☐ No
sleep disturbance	☐ Yes	☐ No
binges	☐ Yes	☐ No
seizures	☐ Yes	☐ No
medical conditions	☐ Yes	☐ No
assaults	☐ Yes	☐ No
job loss	☐ Yes	☐ No
blackouts	☐ Yes	☐ No
tolerance changes	☐ Yes	☐ No
suicidal impulse	☐ Yes	☐ No
arrests	☐ Yes	☐ No
overdose	☐ Yes	☐ No
loss of control amt used	☐ Yes	☐ No
relationship conflicts	☐ Yes	☐ No
Other (list):	☐ Yes	☐ No

Family Alcohol/Drug Abuse History *(Check all that apply)*		
Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Spouse/Partner	☐ Yes	☐ No
Step-Parent/Live-in	☐ Yes	☐ No
Uncles/Aunts	☐ Yes	☐ No
Grandparents	☐ Yes	☐ No
Siblings	☐ Yes	☐ No
Children	☐ Yes	☐ No
Other (list):		

Additional Comments:

What is your longest period of abstinence? _____

Have you ever attended:

Alcoholics Anonymous	☐ Yes ☐ No	Cocaine Anonymous	☐ Yes ☐ No
Narcotics Anonymous	☐ Yes ☐ No	Overeaters Anonymous	☐ Yes ☐ No

If you are not currently attending, why did you stop?

_____

_____

_____

Is there a history of any of the following in the family?

		Additional Comments:
Emotional Problems	☐ Yes ☐ No	
Alcohol Abuse	☐ Yes ☐ No	
Drug Abuse	☐ Yes ☐ No	
Behaviour Problems	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Mental Illness (list)	☐ Yes ☐ No	

_____

CLIENT GOALS

What goals does the client hope to reach while in treatment (substance misuse, educational/vocational, spiritual, emotional, physical, family, etc.)

1 _____

_____

_____

2 _____

_____

_____

3 _____

_____

_____

Answer the question: "The most important goal for me right now is?"

_____

_____

_____

_____

_____

_____

_____

MEDICAL/EMOTIONAL/PSYCHIATRIC HISTORY

1. List Name of Primary Care Doctor _____ *Name* _____ *Phone #*

2. Prior psychotherapy ☐ Yes ☐ No

Longest treatment (List all Therapy Providers) _____ *From* *To* *Therapy Provider & Location*

_____ *From* *To* *Therapy Provider & Location*

3. Prior treatment for a psychiatric, emotional, or substance use disorder ☐ Yes ☐ No

Longest treatment (List all Therapy Providers) _____ *From* *To* *Therapy Provider & Location*

_____ *From* *To* *Therapy Provider & Location*

Diagnosis _____

_____

_____

List All Current Medications - psychiatric & non-psychiatric	
Medication	Dose/Frequency

List all Known Allergies:

Describe any serious hospitalization or accidents

Date	*Age*	*Description*

Describe any abnormal medical test results

Date	*Age*	*Description*

Marital Status

Single	☐ Yes ☐ No	Married	☐ Yes ☐ No
Common-Law	☐ Yes ☐ No	Divorced	☐ Yes ☐ No
Separated	☐ Yes ☐ No		

Describe any past or current significant issues in intimate relationships

Describe any past or current significant issues in immediate family relationships

List all Persons Current Living in Client's Home

Name	*Age*	*Sex*	*Relationship to Client*
Name	*Age*	*Sex*	*Relationship to Client*
Name	*Age*	*Sex*	*Relationship to Client*
Name	*Age*	*Sex*	*Relationship to Client*

List children

Name	*Age*	*Sex*	
			☐ Living with client ☐ Client visits ☐ No contact
Name	*Age*	*Sex*	
			☐ Living with client ☐ Client visits ☐ No contact
Name	*Age*	*Sex*	
			☐ Living with client ☐ Client visits ☐ No contact
Name	*Age*	*Sex*	
			☐ Living with client ☐ Client visits ☐ No contact
Name	*Age*	*Sex*	

How frequently do you visit your children not living with you?

LEGAL HISTORY

Check all that apply and list details

1. Currently on Probation/Parole ☐ Yes ☐ No

List Conditions _____

_____

_____

2. Arrests ☐ Yes ☐ No

_____

_____

_____

3. Jail/Prison time ☐ Yes ☐ No

_____

_____

_____

Describe most recent legal issue

_____

_____

_____

EMPLOYMENT

Currently Employed ☐ Yes ☐ No

Length of unemployment _____

Explain _____

Current Employer _____

Position _____