Fort Frances Tribal Area
HEALTH SERVICES

RESIDENTIAL TREATMENT INTAKE FORM

Disclaimer: *In order to provide you with the best possible service, fields with an *asterisk must be filled in. Incomplete forms cannot be processed.*

Basic Identifying Information

*** First Name:**	***Last Name:**	
Current Address:	***City & Province:**	
Postal Code:	***Phone #:**	
Health Card:	**Email Address:**	
***Birthday (DD/MM/YYYY):**	***Age:**	**Gender:** **Preferred Pronouns:**
Family Origin: ☐ First Nations ☐ Metis ☐ Aboriginal (First Nations Non-Status) ☐ Non Aboriginal ☐ Unknown / Decline	**Community:** _____ **Residing:** ☐ On ☐ Off	
	Clan:	
	Spiritual Advisor:	
Status Card #:	**Preferred Language:**	
Suicide Risk: ☐ High ☐ Medium ☐ Low ☐ Not Applicable		
Referral Source: ☐ Self ☐ Service Provider ☐ Family Member		
Do you have a NNADAP worker involved in your care? ☐ Yes ☐ No		

Person to Contact in Case of Emergency:

***Name:**	
***Phone Number** (mandatory):	***Relationship To Applicant:**
Address:	

Legal Status

***Current / Pending Charges:** ☐ Yes ☐ No	
If Yes, please list charges:	
In Jail? ☐ Yes ☐ No	**If Yes, release date (DD/MM/YYYY):**
On Probation? ☐ Yes ☐ No	**If Yes, Start Date (DD/MM/YYYY):** **End Date (DD/MM/YYYY):**
Conditions:	
On Parole? ☐ Yes ☐ No	**If Yes, Start Date (DD/MM/YYYY):** **End Date (DD/MM/YYYY):**
Conditions:	
Do you have to attend criminal court? ☐ Yes ☐ No	**If Yes, when and why?**
Probation Officer:	**Telephone Number:**
Address:	

Past Offences

Please indicate if you had any of the past offences listed below:
(Check all that apply and **identify year of offence**).

- ☐ Arson
- ☐ Assault
- ☐ Break & Enter
- ☐ Burglary
- ☐ Drug charges
- ☐ Forgery
- ☐ Impaired driving
- ☐ Manslaughter
- ☐ Murder
- ☐ Parole violation
- ☐ Probation violation
- ☐ Criminal negligence causing death
- ☐ Robbery
- ☐ Sexual assault
- ☐ Theft
- ☐ Weapons offence
- ☐ Willful damage/mischief
- ☐ Possession of stolen property

Substance Use

Please list below in order of frequency what substances you are currently misusing chronically:

Substance	Last Date Used	Route of Administration	Average Daily Amount (Hrs)

Treatment / Detoxification History

Please include the two most recent treatment or detox programs you have accessed:

Name of Facility	Date Attended (DD/MM/YYYY)	Completed (Y/N)	Program Length (weeks)

Medical History

Family Doctor Name:	Telephone:
Address:	

Pharmacy Name:	Telephone:
Address:	

Medications

Please list any medications below:

Name:	Dose:	Prescribed by:
When it started:	Reason Prescribed:	

Medications (continued)

Name:	**Dose:**	**Prescribed by:**
When it started:	**Reason Prescribed:**	

Name:	**Dose:**	**Prescribed by:**
When it started:	**Reason Prescribed:**	

Name:	**Dose:**	**Prescribed by:**
When it started:	**Reason Prescribed:**	

Do you have any allergies? ☐ Yes ☐ No

Is an Epi-Pen required for the above allergies? ☐ Yes ☐ No

Harm Reduction – Reducing your risks when using

Are you currently using a harm reduction model of care?
(Methadone, Suboxone or Sublocade)

☐ Yes ☐ No

If yes, what is: Your current dose: _____ Your initial dose: _____

Do you have any physical health concerns that we should be aware of?

Employment Status

☐ Employed (FT, PT, Seasonal, Training) ☐ Unemployed ☐ Retired

Income Source

☐ Employment ☐ Employment Insurance ☐ Ontario Works ☐ ODSB ☐ No Income

*** Mental Health History**

Mental Illness		Description
Been diagnosed with mental illness(es) *	☐ Yes ☐ Unknown ☐ No	
Currently being treated for mental illness(es) *	☐ Yes ☐ Unknown ☐ No	
Currently on psychiatric medication *	☐ Yes ☐ Unknown ☐ No ☐ N/A	
Taking medication consistently *	☐ Yes ☐ Unknown ☐ No ☐ N/A	
Previous suicide attempts *	☐ Yes ☐ Unknown ☐ No	
Hospitalized for mental health/suicide attempts *	☐ Yes ☐ Unknown ☐ No	

Living Situation

Current Living / Housing Status:

☐ Independently ☐ With family/partner ☐ Group home ☐ Hospital

☐ No fixed address ☐ Other _____

Family Background and History

Current Marital Status

☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse/Partner: _____

Length of Relationship: _____

Do you have any dependent children? ☐ Yes ☐ No

Are there child(ren) involved in agencies? ☐ Yes ☐ No

Family Background and History (continued)

Parents		
Mother's Name:		☐ Living ☐ Deceased
Father's Name:		☐ Living ☐ Deceased
Step-Mother's Name:		☐ Living ☐ Deceased
Step-Father's Name:		☐ Living ☐ Deceased
Children's Names		
	☐ Biological ☐ Step-child ☐ Adopted	☐ Living ☐ Deceased
	☐ Biological ☐ Step-child ☐ Adopted	☐ Living ☐ Deceased
	☐ Biological ☐ Step-child ☐ Adopted	☐ Living ☐ Deceased
	☐ Biological ☐ Step-child ☐ Adopted	☐ Living ☐ Deceased
	☐ Biological ☐ Step-child ☐ Adopted	☐ Living ☐ Deceased
Brothers' Names		
	☐ Biological ☐ Half / Step	☐ Living ☐ Deceased
	☐ Biological ☐ Half / Step	☐ Living ☐ Deceased
	☐ Biological ☐ Half / Step	☐ Living ☐ Deceased
Sisters' Names		
	☐ Biological ☐ Half / Step	☐ Living ☐ Deceased
	☐ Biological ☐ Half / Step	☐ Living ☐ Deceased
	☐ Biological ☐ Half / Step	☐ Living ☐ Deceased

Beliefs and Strengths

Please briefly describe your belief system:

What do you see as your personal strengths?

Why is attending treatment important to you?

Would you be interested in our Waasodii Omiie Program?
This is a land based pre-treatment and aftercare program. Some of what is offered includes: medicine walks, birch bark harvesting, full moon ceremonies, links to healers and elders and much more.

☐ Yes ☐ No

If you select yes, a referral will be sent on your behalf.

***Application Checklist**

***Confirmation of transportation to Residential Treatment:** Describe:	☐ Yes ☐ No
***Confirmation of transportation to upon discharge:** Describe:	☐ Yes ☐ No
*Client understands there is an expectation and requirement to be **alcohol and drug free for 14 days prior to admission** to residential treatment. Clients will be urine screened prior to admissions.	☐ Yes ☐ No

Client Signature **Date (DD/MM/YYYY)**

Please forward your completed package to the following:

Intake Worker
Phone: (807) 274-2042 ex. 6221
Phone: (807) 274-7373

Fax: (807) 274-9941
Email: bhsintake@fftahs.org

Mailing Address:
601 King's Highway
Fort Frances, ON
P9A 2X1

Now what happens?

Our intake worker will connect with you in the next 1-3 business days to schedule an intake interview. The interview process includes reviewing your admissions package, completing an assessment and ensuring program suitability. It is also an opportunity for potential clients to ask any questions they may have about the centre or Fort Frances Tribal Area Health Services Programs. After such interview, suitability is determined and an upcoming treatment date can be provided pending acceptance.

For office use only

Date of Completion (DD/MM/YYYY)	**Intake Date (DD/MM/YYYY)**
Eligibility	**Admission Date (DD/MM/YYYY)**