



**ASSESSMENT FOR TWC SUPPORT RECOVERY  
PART 1 – PERSONAL INFORMATION**

**Client Last Name** \_\_\_\_\_ **First** \_\_\_\_\_

**SIN #** \_\_\_\_\_ **Date Of Birth** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Age** \_\_\_\_\_  
DD MM YY

**Gender ID** F  M  Transgender  **PHN#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Cultural / Ethnic ID** \_\_\_\_\_ **Other Language(s)** \_\_\_\_\_

**Address** \_\_\_\_\_ **Postal Code** \_\_\_\_\_

**Contact #** 1 \_\_\_\_\_ 2 \_\_\_\_\_ **Message**  Yes  No

**Emergency Contact** \_\_\_\_\_ **Message**  Yes  No  
Name Relationship Tel

**Dependent Children** (enter # of children in box) None reported  Living with client  Living with separated spouse/partner   
Living with family member  In foster care  Other \_\_\_\_\_

**Employment Status** Full-time  Part-time  Unemployed

**Income Status** Employment  EI  Pension  IA  IA Application Date \_\_\_\_\_  
*Financial information for per diem funding must be confirmed before admission into the TWC Program*

**Per Diem Coverage** Self  IA  ADS Subsidy  Other \_\_\_\_\_

**PART 2 – CURRENT STATUS**

**Current Situation / Areas of Concern** (including crisis or circumstances leading to treatment)

\_\_\_\_\_

\_\_\_\_\_

**Priority?** No  In Detox  Pregnant  Homeless  HIV+ /Other Health Issues

Other Crises \_\_\_\_\_

**Safety Concerns / History or Current Violence in Relationships**

\_\_\_\_\_

**Legal** None Reported  Pending Court Dates \_\_\_\_\_  
Charges \_\_\_\_\_  
Convictions Sexual Offences  Violent Crimes (eg, weapons, assaults)   
Outstanding Warrants (what/where) \_\_\_\_\_  
Probation/Parole (how long/conditions) \_\_\_\_\_

**Know anybody in a support recovery facility now?** No  Yes  Facility Name \_\_\_\_\_



**PART 3 – PHYSICAL HEALTH**

**Medical Diagnoses / Major Illnesses: Any diagnosed conditions/illnesses eg MS/Diabetes/Meningitis, Emphysema**

**Other Current Physical Health Issues such as cold, influenza or chronic conditions as back/knee pain, Migraines**

**Communicable Diseases** None Reported  TB  HIV  Hep A B or C  Other \_\_\_\_\_  
Last Date Tested \_\_\_\_\_

Physician for pre-natal care \_\_\_\_\_ Tel \_\_\_\_\_

**Relevant Medical History / Prior Hospitalizations**

Family History

Operations

**Current Medications** (prescription, OTC, supplements)

Name	Condition Being Treated	Current RX Date	How Long on This

**Methadone Maintenance Therapy** Never   
**Past**  **Current**   
 When \_\_\_\_\_ How Long on MMT \_\_\_\_\_  
 How Long on MMT \_\_\_\_\_ Current Dose \_\_\_\_\_  
 Dose \_\_\_\_\_ Maintenance  Reduction  Carry Privileges Yes  No   
 Prescribing Physician \_\_\_\_\_ Name \_\_\_\_\_ Tel \_\_\_\_\_

**Allergies** (drug, food, environmental – include reactions) \_\_\_\_\_

**Special Needs / Disabilities** \_\_\_\_\_

**Special Aids Used** \_\_\_\_\_



# TOGETHER WE CAN

Addiction Recovery & Education Society

Drug & Alcohol Recovery & Education Society

2831 Kingsway, Vancouver BC V5R 5H9  
Tel: (604) 451 - 9854 Fax: (604) 451 - 8863  
Web Site: [www.twcrecoverylife.org](http://www.twcrecoverylife.org)  
Email: [info@twcrecoverylife.org](mailto:info@twcrecoverylife.org)

## PART 4 – MENTAL HEALTH

### Mental Health History / Symptoms (include psychiatric diagnoses, hospitalizations, other treatment)

Have you ever seen a psychiatrist? Been Diagnosed with a mental illness? Who diagnosed you and when? What are your symptoms? Are you on medications? What and for how long? Are the medications managing your symptoms? Do you take your medication(s) consistently? If you hear voices, what is the content?

### Self-Harming Behaviours (eating disorders, slashing, burning)

Past or current behaviours? If you have had a current event, what happened? Have you had any help in the past?

**Suicide Risk**    current     ideation     previous attempts     When/What happened? Hospitalization? Family history?

### Current Mood / Presenting Symptoms

Reported: \_\_\_\_\_  
\_\_\_\_\_

Professional Observations: how do you see client's mood? E.g. flat, fearful? \_\_\_\_\_  
\_\_\_\_\_



**PART 5 - ADDICTIONS**

<b>Substance Use History</b> Fill in for each substance Enter "0" if not applicable	<b>Method:</b> 1 = Oral 2 = Snort/Sniff 3 = Smoke/Chase 4 = Intravenous 5 = Intramuscular	Amount	Frequency	Years of Use	Date Last Used
Alcohol					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Crack					
Crystal Meth					
Ecstasy					
Hallucinogens					
Heroin					
Illicit Methadone					
Inhalants					
Nicotine					
Opiates other than heroin/methadone					
Misuse of other Prescription Meds					
Speedball (Cocaine/Heroin)					

**Other Addictions (sex, food, gambling, etc)**

**Previous Addictions Support / Treatment**

Agency (Name)	Dates	Outcomes	Comments



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## PART 6 - PROFESSIONALS INVOLVED

	Name	Agency / Office	Tel
Physician (G.P.)			
Addictions Physician			
Psychiatrist			
Mental Health Team			
A & D Counselling			
Health Centre			
Dual Diagnosis			
IA (MEIA)			
MCFD Social Worker			
Legal			
Parole / Probation			
Other Counsellor			

## PART 7 - VERIFICATION

### Client Authorization

I \_\_\_\_\_, verify that the information provided here is true to the best of my knowledge.  
Print Name

I understand that the information in this assessment will be shared with Together We Can professional staff involved in my care.

I understand that the financial information in this assessment will be verified by Together We Can before admission into the program and give my release to Together We Can to confirm funding as per information provided.

Client Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YY

### Staff Verification if Applicable

Completed by \_\_\_\_\_  
Please Print

Site \_\_\_\_\_

Staff Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Day Month Year