**A cartoon of a person and a drum

AI-generated content may be incorrect.**

**NNADAP/YSAC Family Intake & Referral Application**

**Primary Participant**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date of Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Program start date(s) participant is willing to enter treatment on (MM/DD/YYYY): **\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the participant is flexible and willing to enter treatment at any of multiple program start dates, please list all viable dates, however, participant will only be permitted to attend one session.

Your participant is applying to the program as:

* Single mom with children
* Single dad with children
* Couple with children
* Couple with no children
* Extended family with children

**Number of Children Attending the Program: \_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | | | | | | | | | | | | |
| Surname: | | | | | | | | | First Name: | | | | | | | | | | | |
| Nickname or other name known by: | | | | | | | | | Date of Birth: | | | | | | | | | | | |
| Health Card Number: | | | | | | Health Card Expiry Date: | | | Age: | | | | | | | Sex:   * Female * Male | | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | | | | | Client Address: | | | | | | | | | | Client Phone: | | | | |
| Language Spoken: | | | | | | Language Preferred: | | | | | | | | | | Language Understood: | | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Elidigable for Status | | | | | | | | | Treaty Number: | | | | | | | | | | | |
| Band Name: | | | | | | | | | | | |
| Other Indigenous Status: | | | | | | | | | Relationship Status: | | | | | | | | | | | |
| Emergency Contact Name: | | | | | | | | | Emergency Contact Relationship: | | | | | | | | | | | |
| Emergency Contact Phone Number: | | | | | | | | | Next of Kin: | | | | | | | | | | | |
| Relationship to Next of Kin: | | | | | | | | | Next of Kin Phone: | | | | | | | | | | | |
| Education:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | | | | | Literacy Level:   * Illiterate * Literate * Needs assistance | | | | Income Source:   * Employment Insurance (EI) * None * Other * Assistance (Social Assistance or Government) * Disability * Employment Income/Occupation | | | | | | | | | | | |
| Employment Status:   * Self-Employed * Full Time Seasonal * Part Time Student * Disability Assistance * Retired * Homemaker * Full Time Employment * Part Time Seasonal * Unemployed * Worker’s Compensation * Student * Other * Part Time Employment * Full Time Student * Social Assistance * Volunteer * Training | | | | | | | | | | | | | | | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | | | | | | | | | | | | |
| *Is this family receiving any additional supports from Jordan’s Principle Programs?*   * Unsure * No * Yes   ***If yes, please describe:*** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **B. Legal Status**   * Unknown * Yes | | | | | | | | | | | | | | | | | | | | |
| *Has your client ever been in trouble with the law?*   * No   ***If yes, please explain:*** | | | | | | | | | | | | | | | | | | | | |
| *Is your client under any of*   * Criminal Court * Family Court * Drug Court Treatment * Probation * Charges Pending * Court Referral * Court Order * Restorative Justice * No Involvement * Unknown   *these legal involvements?* | | | | | | | | | *Is the client under any of the following legal conditions?*   * Bail * Parole * Temporary Absence Order * No Involvement * Unknown * Other   **If other, please specify:** | | | | | | | | | | | |
| *Gang Involvement:*   * Unknown * Yes * No | | | | | | | | | | | | | | | | | | | | |
| *Was alcohol or any other substances, such as ‘sniff’ or other drugs involved in your client’s legal dealing?*  **If other, please specify:**   * Yes * No * Other * Unknown | | | | | | | | | | | | | | | | | | | | |
| *Is your client seeking treatment as a result of a court order or family service order?*  **If yes, please explain:**   * Yes * No * Unknown | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **C. Children** | | | | | | | | | | | | | | | | | | | | |
| *Other children and their child welfare status* ***(Not attending treatment immediately):*** | | | | | | | | | | | | | | | | | | | | |
| Name | | | Date of Birth | | Provincial Health Number & Expiry Date | | | | | Status # | | | | Sex | | | | | Custody Information | |
|  | | |  | |  | | | | |  | | | | * Female * Male * Other:   \_\_\_\_\_\_\_\_\_ | | | | | * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) | |
|  | | |  | |  | | | | |  | | | | * Female * Male * Other:   \_\_\_\_\_\_\_\_\_ | | | | | * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) | |
|  | | |  | |  | | | | |  | | | | * Female * Male * Other:   \_\_\_\_\_\_\_\_\_ | | | | | * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) | |
|  | | |  | |  | | | | |  | | | | * Female * Male * Other:   \_\_\_\_\_\_\_\_\_ | | | | | * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) | |
| *Children’s education and social status* ***(Not attending treatment immediately):*** | | | | | | | | | | | | | | | | | | | | |
| Child | Grade Level | | | Has an Individual Education Plan | | | | Has an Academic Assessment | | | | Has Received Guidance Counselling | | | | | Has been previously apprehended | | | Has received a Behaviour Assessment |
|  |  | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  |  | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  |  | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  |  | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | * Yes * No * Unknown | | | | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  | | | | | | | | | | | | | | | | | | | | |
| **D. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | | | | | | | | | | | | |
| *At what age did your client start sniffing?* | | | | | | | | | | | *At what age did your client start drinking?* | | | | | | | | | |
| *At what age did your client start using other drugs?* | | | | | | | | | | | | | | | | | | | | |
| *Does anyone else in their family use solvents/substances?*   * Yes * No * Unknown   **If yes, please specify:** | | | | | | | | | | | | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | | | | | | | | | | | | |
| *Has client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | | | | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | | | | | | | | | | | | |
| **Treatment Location** | | | | | | **Treatment Date** | | | | | | | | | **Describe** | | | | | |
|  | | | | | |  | | | | | | | | | *(Completed/Not Completed?)* | | | | | |
| Has your client used substances for the last year?  Yes  No  Unknown  **If yes, complete a DUSI-R Assessment.** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **E. Pre-Treatment** | | | | | | | | | | | | | | | | | | | | |
| *Has the client attended a pre-treatment counselling session with you?*  **If yes, please explain:** | | | | | | | | | | | | | | | | | | | | * Yes * No * Unknown |
| *Has the client attended any withdrawal management prior to coming to the treatment centre?*  **If yes, please explain:** | | | | | | | | | | | | | | | | | | | | * Yes * No * Unknown |
|  | | | | | | | | | | | | | | | | | | | | |
| **F. Withdrawal Symptoms** | | | | | | | | | | | | | | | | | | | | |
| *Has your client experienced any of the following symptoms while withdrawing from substances in the last*  *6 months?* | | | | | | | | | | | | | | | | | | | | |
| Symptoms | | | | | | | | | | | Describe | | | | | | | | | |
| *Blackouts*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Hallucinations*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Nausea/Vomiting*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Seizures*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Shakes*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Delirium Tremens (DTs)*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Ever experienced DTs?*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **G. Mental Health History** | | | | | | | | | | | | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | | | | | | | | | | | | |
| Mental Illness | | | | | | | | | | | Describe | | | | | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Has your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | | | | | | | | |  | | | | | | | | | |
| **Treatment Location: Treatment Date:** | | | | | | | | | | | **Describe:** | | | | | | | | | |
| **If any treatment program was NOT completed, please provide details:** | | | | | | | | | | | | | | | | | | | | |
| *Has your primary participant participated in other programs/services i.e., Relationship counselling, anger management or depression?*   * Yes * No * Unknown   **If yes, when and describe:** | | | | | | | | | | | | | | | | | | | | |
| **Year** | | **Treatment Centre** | | | | | **Type of Addiction** | | | | | | **Completed** | | | | | **Comments** | | |
|  | |  | | | | |  | | | | | | * Yes * No * Unknown | | | | |  | | |
|  | |  | | | | |  | | | | | | * Yes * No * Unknown | | | | |  | | |
|  | |  | | | | |  | | | | | | * Yes * No * Unknown | | | | |  | | |
|  | |  | | | | |  | | | | | | * Yes * No * Unknown | | | | |  | | |
| Reasons for currently requesting treatment (please comment on motivation and participant strength):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **H. Social Functioning** | | | | | | | | | | | | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | | | | | | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | | | | | | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | | | | | | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | | | | | | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | | | | | | | | | | | | |
| * Sexually aggressive behaviors or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviors * Verbally aggressive abusive, or threatening behaviors * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | | | | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify the eating disorder:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | | | | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviors (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | | | | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | | | | | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **I. Historical Trauma Event** | | | | | | | | | | | | | | | | | | | | |
| *Has your client experienced historical trauma?*   * Yes * No * Unknown | | | | | | | | | | | | | | | | | | | | |
| *What kind of historical trauma has your client experienced? Please select.*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **J. Client’s Stage of Readiness** | | | | | | | | | | | | | | | | | | | | |
| * Pre-contemplation – Not considering change, resistant to change * Contemplation – Unsure of whether to change, chronic indecision * Determination – Preparation; committed to changing behaviour within one month * Action – Begin behaviour change * Maintenance – Behaviour change has persisted for 6 months or more   *Please list any questions or concerns the client has indicated during the intake process:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | | | | | | | | | | | | |

****

**NNADAP/YSAC Family Intake & Referral Application**

**Spouse / Partner**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date of Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | |
| Surname: | | | First Name: | | | | | | |
| Nickname or other name known by: | | | Date of Birth: | | | | | | |
| Health Card Number: | | Health Card Expiry Date: | Age: | | | Sex:   * Female * Male | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | Client Address: | | | | Client Phone Number: | | | |
| Language Spoken: | | Language Preferred: | | | | Language Understood: | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Eligible for Status | | | Treaty Number: | | | | | | |
| Band Name: | | | | | | |
| Other Indigenous Status: | | | Relationship Status: | | | | | | |
| Emergency Contact Name: | | | Emergency Contact Relationship: | | | | | | |
| Emergency Contact Phone Number: | | | Next of Kin: | | | | | | |
| Relationship to Next of Kin: | | | Next of Kin Phone Number: | | | | | | |
| Education:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | Literacy Level:   * Illiterate * Literate * Needs assistance | | Income Source:   * Assistance (Social Assistance or Government) * Disability * Employment Income/Occupation * Employment Insurance (EI) * None * Other | | | | | | |
| Employment Status:   * Part Time Employment * Full Time Student * Social Assistance * Volunteer * Training * Full Time Employment * Part Time Seasonal * Unemployed * Worker’s Compensation * Student * Other * Self-Employed * Full Time Seasonal * Part Time Student * Disability Assistance * Retired * Homemaker | | | | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | |
|  | | | | | | | | | |
| **B. Legal Status**   * Unknown * No * Yes | | | | | | | | | |
| *Has your client ever been in trouble with the law?*  ***If yes, please explain:***   * Criminal Court * Family Court * Drug Court Treatment * Probation * Charges Pending * Court Referral * Court Order * Restorative Justice * No Involvement * Unknown | | | | | | | | | |
| *Is your client under any of*  *these legal involvements?* | | | *Is your client under any of the following legal conditions?*   * Bail * Parole * Temporary Absence Order * No Involvement * Other * Unknown   **If other, please specify:** | | | | | | |
| *Gang Involvement:*   * Unknown * Yes * No | | | | | | | | | |
| *Was alcohol or any other substances, such as ‘sniff’ or other drugs involved in your client’s legal dealing?*  **If other, please specify:**   * Yes * No * Other * Unknown | | | | | | | | | |
| *Is your client seeking treatment as a result of a court order or family service order?*  **If yes, please explain:**   * Yes * No * Unknown | | | | | | | | | |
|  | | | | | | | | | |
| **C. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | |
| *At what age did your client start sniffing?* | | | | *At what age did your client start drinking?* | | | | | |
| *At what age did your client start using drugs?* | | | | | | | | | |
| *Does anyone else in their family use solvents/substances?*   * Yes * No * Unknown   **If yes, please specify:** | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has the client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown | | | | | | | | | |
| ***Treatment Location*** | | ***Treatment Date*** | | | ***Describe*** | | | | |
|  | |  | | | *(Completed/Not Completed?)* | | | | |
| Has your client used substances for the last year?     * Yes * No * Unknown **If yes, complete a DUSI-R Assessment.** | | | | | | | | | |
|  | | | | | | | | | |
| **D. Pre-Treatment** | | | | | | | | | |
| *Has the client attended a pre-treatment counselling session with you?*  **If yes, please explain:** | | | | | | | | | * Yes * No * Unknown |
| *Has the client attended any withdrawal management prior to coming to the treatment centre?*  **If yes, please explain:** | | | | | | | | | * Yes * No * Unknown |
|  | | | | | | | | | |
| **E. Withdrawal Symptoms** | | | | | | | | | |
| *Has your client experienced any of the following symptoms while withdrawing from substances in the last*  *6 months?* | | | | | | | | | |
| **Symptoms** | | | | **Describe** | | | | | |
| *Blackouts*   * Yes * No * Unknown | | | |  | | | | | |
| *Hallucinations*   * Yes * No * Unknown | | | |  | | | | | |
| *Nausea/Vomiting*   * Yes * No * Unknown | | | |  | | | | | |
| *Seizures*   * Yes * No * Unknown | | | |  | | | | | |
| *Shakes*   * Yes * No * Unknown | | | |  | | | | | |
| *Delirium Tremens (DTs)*   * Yes * No * Unknown | | | |  | | | | | |
| *Ever experienced DTs?*   * Yes * No * Unknown | | | |  | | | | | |
|  | | | | | | | | | |
| **F. Mental Health History** | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | |
| **Mental Illness** | | | | **Describe** | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | |  | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | |  | | | | | |
| *Had your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | |  | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | |  | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | |  | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | |  | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | |  | | | | | |
| **Treatment Location: Treatment Date:** | | | | **Describe:** | | | | | |
| *If any treatment program was NOT completed, please provide details:* | | | |  | | | | | |
|  | | | | | | | | | |
| **G. Social Functioning** | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | |
| * Sexually aggressive behaviours or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviours * Verbally aggressive, abusive, or threatening behaviours * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviours (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | |
|  | | | | | | | | | |
| **H. Historical Trauma Event** | | | | | | | | | |
| *Has your client experienced historical trauma?* | | | | | | | | * Yes * No * Unknown | |
| *What kind of historical trauma has your client experienced?*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

****

**NNADAP/YSAC Family Intake & Referral Application**

**Child / Dependent #1**

**PLEASE COMPLETE A CHILD APPLICATION FOR EACH CHILD ATTENDING THE PROGRAM**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | |
| Surname: | | | First Name: | | | | | | |
| Nickname or other name known by: | | | Date of Birth: | | | | | | |
| Health Card Number: | | Health Card Expiry Date: | Age: | | | Sex:   * Female * Male | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | Client Address: | | | | Client Phone: | | | |
| Language Spoken: | | Language Preferred: | | | | Language Understood: | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Eligible for Status | | | Treaty Number: | | | | | | |
| Band Name: | | | | | | |
| Other Indigenous Status: | | | Relationship Status: | | | | | | |
| Emergency Contact Name: | | | Emergency Contact Relationship: | | | | | | |
| Emergency Contact Phone Number: | | | Next of Kin: | | | | | | |
| Relationship to Next of Kin:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | | | Next of Kin Phone Number: | | | | | | |
| Education: | | | Literacy Level:   * Illiterate * Literate * Needs assistance | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | |
| Custody Information:   * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services | | | | | | | | | |
| Social Worker Name and Contact Information: | | | | | | | | | |
|  | | | | | | | | | |
| **B. Education and Social Status** | | | | | | | | | |
| Grade Level | Has an Individual Education Plan | Has an Academic Assessment | | Has Received Guidance Counselling | | Has been previously apprehended | | | Has received a Behaviour Assessment |
|  | * Yes * No * Unknown | * Yes * No * Unknown | | * Yes * No * Unknown | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  | | | | | | | | | |
| **C. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| **Treatment Location** | | **Treatment Date** | | | **Describe** | | | | |
|  | |  | | | *(Completed/Not Completed?)* | | | | |
| Has your client used substances for the last year?  Yes  No  Unknown  **If yes, complete a DUSI-R Assessment.** | | | | | | | | | |
|  | | | | | | | | | |
| **D. Mental Health History** | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | |
| Mental Illness | | | | Describe | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | |  | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | |  | | | | | |
| *Eating (obesity, anorexia, bulimia, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Sex (promiscuity, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Internet / Texting*   * Yes * No * Unknown | | | |  | | | | | |
| *Gaming (video games and APP games)*   * Yes * No * Unknown | | | |  | | | | | |
| *Had your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | |  | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | |  | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | |  | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | |  | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | |  | | | | | |
| ***Treatment Location: Treatment Date:*** | | | | **Describe:** | | | | | |
| *If any treatment program was NOT completed, please provide details:* | | | |  | | | | | |
|  | | | | | | | | | |
| **E. Social Functioning** | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | |
| * Sexually aggressive behaviors or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviors * Verbally aggressive abusive, or threatening behaviors * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviours (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | |
|  | | | | | | | | | |
| **H. Historical Trauma Event** | | | | | | | | | |
| *Has your client experienced historical trauma?* | | | | | | | | * Yes * No * Unknown | |
| *What kind of historical trauma has your client experienced?*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

****

**NNADAP/YSAC Family Intake & Referral Application**

**Child / Dependent #2**

**PLEASE COMPLETE A CHILD APPLICATION FOR EACH CHILD ATTENDING THE PROGRAM**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | |
| Surname: | | | First Name: | | | | | | |
| Nickname or other name known by: | | | Date of Birth: | | | | | | |
| Health Card Number: | | Health Card Expiry Date: | Age: | | | Sex:   * Female * Male | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | Client Address: | | | | Client Phone: | | | |
| Language Spoken: | | Language Preferred: | | | | Language Understood: | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Eligible for Status | | | Treaty Number: | | | | | | |
| Band Name: | | | | | | |
| Other Indigenous Status: | | | Relationship Status: | | | | | | |
| Emergency Contact Name: | | | Emergency Contact Relationship: | | | | | | |
| Emergency Contact Phone Number: | | | Next of Kin: | | | | | | |
| Relationship to Next of Kin:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | | | Next of Kin Phone Number: | | | | | | |
| Education: | | | Literacy Level:   * Illiterate * Literate * Needs assistance | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | |
| Custody Information:   * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services | | | | | | | | | |
| Social Worker Name and Contact Information: | | | | | | | | | |
|  | | | | | | | | | |
| **B. Education and Social Status** | | | | | | | | | |
| Grade Level | Has an Individual Education Plan | Has an Academic Assessment | | Has Received Guidance Counselling | | Has been previously apprehended | | | Has received a Behaviour Assessment |
|  | * Yes * No * Unknown | * Yes * No * Unknown | | * Yes * No * Unknown | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  | | | | | | | | | |
| **C. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| **Treatment Location** | | **Treatment Date** | | | **Describe** | | | | |
|  | |  | | | *(Completed/Not Completed?)* | | | | |
| Has your client used substances for the last year?  Yes  No  Unknown  **If yes, complete a DUSI-R Assessment.** | | | | | | | | | |
|  | | | | | | | | | |
| **D. Mental Health History** | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | |
| Mental Illness | | | | Describe | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | |  | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | |  | | | | | |
| *Eating (obesity, anorexia, bulimia, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Sex (promiscuity, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Internet / Texting*   * Yes * No * Unknown | | | |  | | | | | |
| *Gaming (video games and APP games)*   * Yes * No * Unknown | | | |  | | | | | |
| *Had your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | |  | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | |  | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | |  | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | |  | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | |  | | | | | |
| ***Treatment Location: Treatment Date:*** | | | | **Describe:** | | | | | |
| *If any treatment program was NOT completed, please provide details:* | | | |  | | | | | |
|  | | | | | | | | | |
| **E. Social Functioning** | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | |
| * Sexually aggressive behaviors or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviors * Verbally aggressive abusive, or threatening behaviors * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviours (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | |
|  | | | | | | | | | |
| **H. Historical Trauma Event** | | | | | | | | | |
| *Has your client experienced historical trauma?* | | | | | | | | * Yes * No * Unknown | |
| *What kind of historical trauma has your client experienced?*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

****

**NNADAP/YSAC Family Intake & Referral Application**

**Child / Dependent #3**

**PLEASE COMPLETE A CHILD APPLICATION FOR EACH CHILD ATTENDING THE PROGRAM**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | |
| Surname: | | | First Name: | | | | | | |
| Nickname or other name known by: | | | Date of Birth: | | | | | | |
| Health Card Number: | | Health Card Expiry Date: | Age: | | | Sex:   * Female * Male | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | Client Address: | | | | Client Phone: | | | |
| Language Spoken: | | Language Preferred: | | | | Language Understood: | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Eligible for Status | | | Treaty Number: | | | | | | |
| Band Name: | | | | | | |
| Other Indigenous Status: | | | Relationship Status: | | | | | | |
| Emergency Contact Name: | | | Emergency Contact Relationship: | | | | | | |
| Emergency Contact Phone Number: | | | Next of Kin: | | | | | | |
| Relationship to Next of Kin:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | | | Next of Kin Phone Number: | | | | | | |
| Education: | | | Literacy Level:   * Illiterate * Literate * Needs assistance | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | |
| Custody Information:   * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services | | | | | | | | | |
| Social Worker Name and Contact Information: | | | | | | | | | |
|  | | | | | | | | | |
| **B. Education and Social Status** | | | | | | | | | |
| Grade Level | Has an Individual Education Plan | Has an Academic Assessment | | Has Received Guidance Counselling | | Has been previously apprehended | | | Has received a Behaviour Assessment |
|  | * Yes * No * Unknown | * Yes * No * Unknown | | * Yes * No * Unknown | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  | | | | | | | | | |
| **C. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| **Treatment Location** | | **Treatment Date** | | | **Describe** | | | | |
|  | |  | | | *(Completed/Not Completed?)* | | | | |
| Has your client used substances for the last year?  Yes  No  Unknown  **If yes, complete a DUSI-R Assessment.** | | | | | | | | | |
|  | | | | | | | | | |
| **D. Mental Health History** | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | |
| Mental Illness | | | | Describe | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | |  | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | |  | | | | | |
| *Eating (obesity, anorexia, bulimia, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Sex (promiscuity, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Internet / Texting*   * Yes * No * Unknown | | | |  | | | | | |
| *Gaming (video games and APP games)*   * Yes * No * Unknown | | | |  | | | | | |
| *Had your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | |  | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | |  | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | |  | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | |  | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | |  | | | | | |
| ***Treatment Location: Treatment Date:*** | | | | **Describe:** | | | | | |
| *If any treatment program was NOT completed, please provide details:* | | | |  | | | | | |
|  | | | | | | | | | |
| **E. Social Functioning** | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | |
| * Sexually aggressive behaviors or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviors * Verbally aggressive abusive, or threatening behaviors * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviours (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | |
|  | | | | | | | | | |
| **H. Historical Trauma Event** | | | | | | | | | |
| *Has your client experienced historical trauma?* | | | | | | | | * Yes * No * Unknown | |
| *What kind of historical trauma has your client experienced?*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

****

**NNADAP/YSAC Family Intake & Referral Application**

**Child / Dependent #4**

**PLEASE COMPLETE A CHILD APPLICATION FOR EACH CHILD ATTENDING THE PROGRAM**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | |
| Surname: | | | First Name: | | | | | | |
| Nickname or other name known by: | | | Date of Birth: | | | | | | |
| Health Card Number: | | Health Card Expiry Date: | Age: | | | Sex:   * Female * Male | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | Client Address: | | | | Client Phone: | | | |
| Language Spoken: | | Language Preferred: | | | | Language Understood: | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Eligible for Status | | | Treaty Number: | | | | | | |
| Band Name: | | | | | | |
| Other Indigenous Status: | | | Relationship Status: | | | | | | |
| Emergency Contact Name: | | | Emergency Contact Relationship: | | | | | | |
| Emergency Contact Phone Number: | | | Next of Kin: | | | | | | |
| Relationship to Next of Kin:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | | | Next of Kin Phone Number: | | | | | | |
| Education: | | | Literacy Level:   * Illiterate * Literate * Needs assistance | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | |
| Custody Information:   * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services | | | | | | | | | |
| Social Worker Name and Contact Information: | | | | | | | | | |
|  | | | | | | | | | |
| **B. Education and Social Status** | | | | | | | | | |
| Grade Level | Has an Individual Education Plan | Has an Academic Assessment | | Has Received Guidance Counselling | | Has been previously apprehended | | | Has received a Behaviour Assessment |
|  | * Yes * No * Unknown | * Yes * No * Unknown | | * Yes * No * Unknown | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  | | | | | | | | | |
| **C. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| **Treatment Location** | | **Treatment Date** | | | **Describe** | | | | |
|  | |  | | | *(Completed/Not Completed?)* | | | | |
| Has your client used substances for the last year?  Yes  No  Unknown  **If yes, complete a DUSI-R Assessment.** | | | | | | | | | |
|  | | | | | | | | | |
| **D. Mental Health History** | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | |
| Mental Illness | | | | Describe | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | |  | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | |  | | | | | |
| *Eating (obesity, anorexia, bulimia, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Sex (promiscuity, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Internet / Texting*   * Yes * No * Unknown | | | |  | | | | | |
| *Gaming (video games and APP games)*   * Yes * No * Unknown | | | |  | | | | | |
| *Had your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | |  | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | |  | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | |  | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | |  | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | |  | | | | | |
| ***Treatment Location: Treatment Date:*** | | | | **Describe:** | | | | | |
| *If any treatment program was NOT completed, please provide details:* | | | |  | | | | | |
|  | | | | | | | | | |
| **E. Social Functioning** | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | |
| * Sexually aggressive behaviors or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviors * Verbally aggressive abusive, or threatening behaviors * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviours (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | |
|  | | | | | | | | | |
| **H. Historical Trauma Event** | | | | | | | | | |
| *Has your client experienced historical trauma?* | | | | | | | | * Yes * No * Unknown | |
| *What kind of historical trauma has your client experienced?*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

****

**NNADAP/YSAC Family Intake & Referral Application**

**Child / Dependent #5**

**PLEASE COMPLETE A CHILD APPLICATION FOR EACH CHILD ATTENDING THE PROGRAM**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | |
| Surname: | | | First Name: | | | | | | |
| Nickname or other name known by: | | | Date of Birth: | | | | | | |
| Health Card Number: | | Health Card Expiry Date: | Age: | | | Sex:   * Female * Male | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | Client Address: | | | | Client Phone: | | | |
| Language Spoken: | | Language Preferred: | | | | Language Understood: | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Eligible for Status | | | Treaty Number: | | | | | | |
| Band Name: | | | | | | |
| Other Indigenous Status: | | | Relationship Status: | | | | | | |
| Emergency Contact Name: | | | Emergency Contact Relationship: | | | | | | |
| Emergency Contact Phone Number: | | | Next of Kin: | | | | | | |
| Relationship to Next of Kin:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | | | Next of Kin Phone Number: | | | | | | |
| Education: | | | Literacy Level:   * Illiterate * Literate * Needs assistance | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | |
| Custody Information:   * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services | | | | | | | | | |
| Social Worker Name and Contact Information: | | | | | | | | | |
|  | | | | | | | | | |
| **B. Education and Social Status** | | | | | | | | | |
| Grade Level | Has an Individual Education Plan | Has an Academic Assessment | | Has Received Guidance Counselling | | Has been previously apprehended | | | Has received a Behaviour Assessment |
|  | * Yes * No * Unknown | * Yes * No * Unknown | | * Yes * No * Unknown | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  | | | | | | | | | |
| **C. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| **Treatment Location** | | **Treatment Date** | | | **Describe** | | | | |
|  | |  | | | *(Completed/Not Completed?)* | | | | |
| Has your client used substances for the last year?  Yes  No  Unknown  **If yes, complete a DUSI-R Assessment.** | | | | | | | | | |
|  | | | | | | | | | |
| **D. Mental Health History** | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | |
| Mental Illness | | | | Describe | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | |  | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | |  | | | | | |
| *Eating (obesity, anorexia, bulimia, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Sex (promiscuity, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Internet / Texting*   * Yes * No * Unknown | | | |  | | | | | |
| *Gaming (video games and APP games)*   * Yes * No * Unknown | | | |  | | | | | |
| *Had your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | |  | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | |  | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | |  | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | |  | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | |  | | | | | |
| ***Treatment Location: Treatment Date:*** | | | | **Describe:** | | | | | |
| *If any treatment program was NOT completed, please provide details:* | | | |  | | | | | |
|  | | | | | | | | | |
| **E. Social Functioning** | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | |
| * Sexually aggressive behaviors or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviors * Verbally aggressive abusive, or threatening behaviors * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviours (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | |
|  | | | | | | | | | |
| **H. Historical Trauma Event** | | | | | | | | | |
| *Has your client experienced historical trauma?* | | | | | | | | * Yes * No * Unknown | |
| *What kind of historical trauma has your client experienced?*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

****

**NNADAP/YSAC Family Intake & Referral Application**

**Child / Dependent #6**

**PLEASE COMPLETE A CHILD APPLICATION FOR EACH CHILD ATTENDING THE PROGRAM**

**PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS**. **Form to be completed by referring agent.**

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

**Date Application Received by Community Worker: (MM/DD/YYYY**) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Application Received by Treatment Centre: (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the referral worker/agency**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Client Information** | | | | | | | | | |
| Surname: | | | First Name: | | | | | | |
| Nickname or other name known by: | | | Date of Birth: | | | | | | |
| Health Card Number: | | Health Card Expiry Date: | Age: | | | Sex:   * Female * Male | | | |
| Gender:   * Gender Fluid * No category describes me * Unknown * Decline to State * Female/Woman * Male/Man * Transgender * Intersex * Two-Spirited * English * French | | Client Address: | | | | Client Phone: | | | |
| Language Spoken: | | Language Preferred: | | | | Language Understood: | | | |
| Nation Status:   * First Nation Non-Status * First Nation Status * Inuit Non-Status * Recognized Inuit * Métis * Client Not Eligible for Status | | | Treaty Number: | | | | | | |
| Band Name: | | | | | | |
| Other Indigenous Status: | | | Relationship Status: | | | | | | |
| Emergency Contact Name: | | | Emergency Contact Relationship: | | | | | | |
| Emergency Contact Phone Number: | | | Next of Kin: | | | | | | |
| Relationship to Next of Kin:   * Less than grade 8 * Completed high school * Not completed high school * Completed post-secondary * Some post-secondary | | | Next of Kin Phone Number: | | | | | | |
| Education: | | | Literacy Level:   * Illiterate * Literate * Needs assistance | | | | | | |
| Living Situation:   * Homeless * Group Home * Shelter * Foster Care * Common Law * Friend * Unknown * On-reserve * Off-reserve * Urban * Rural * Immediate Family * Extended Family * Lives Alone | | | | | | | | | |
| Custody Information:   * Orders of Supervision * Unsupervised Visitation * Continued Supervision * Temporary Supervision * Voluntary Placement Agreement * Continuous Care (Ongoing Family Services) * Customary Traditional * Adoption * Biological * Kinship/Foster * Recent Apprehension * Voluntary Family Services | | | | | | | | | |
| Social Worker Name and Contact Information: | | | | | | | | | |
|  | | | | | | | | | |
| **B. Education and Social Status** | | | | | | | | | |
| Grade Level | Has an Individual Education Plan | Has an Academic Assessment | | Has Received Guidance Counselling | | Has been previously apprehended | | | Has received a Behaviour Assessment |
|  | * Yes * No * Unknown | * Yes * No * Unknown | | * Yes * No * Unknown | | * Yes * No * Unknown | | | * Yes * No * Unknown |
|  | | | | | | | | | |
| **C. Chemical Use History - *Substance misuse prior to treatment history:*** | | | | | | | | | |
| *Has anyone in their family or community received treatment for solvent/substance abuse?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client participated in a non-residential/community-based substance abuse program?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| *Has your client received prior treatment at a residential addiction centre?*   * Yes * No * Unknown   **If yes, please explain:** | | | | | | | | | |
| **Treatment Location** | | **Treatment Date** | | | **Describe** | | | | |
|  | |  | | | *(Completed/Not Completed?)* | | | | |
| Has your client used substances for the last year?  Yes  No  Unknown  **If yes, complete a DUSI-R Assessment.** | | | | | | | | | |
|  | | | | | | | | | |
| **D. Mental Health History** | | | | | | | | | |
| *Provide the following information about the client’s mental health status:* | | | | | | | | | |
| Mental Illness | | | | Describe | | | | | |
| *Been diagnosed with a mental illness*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently being treated*   * Yes * No * Unknown | | | |  | | | | | |
| *Currently on psychiatric medication*   * Yes * No * Unknown | | | |  | | | | | |
| *Taking medication consistently*   * Yes * No * Unknown | | | |  | | | | | |
| *Eating (obesity, anorexia, bulimia, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Sex (promiscuity, etc.)*   * Yes * No * Unknown | | | |  | | | | | |
| *Internet / Texting*   * Yes * No * Unknown | | | |  | | | | | |
| *Gaming (video games and APP games)*   * Yes * No * Unknown | | | |  | | | | | |
| *Had your client ever spoken or written about killing themself?*   * Yes * No * Unknown | | | |  | | | | | |
| *Previous suicide attempts/ideations?* ***If yes, please explain how and when:***   * Yes * No * Unknown | | | |  | | | | | |
| *Hospitalized for suicide attempts?* ***If yes, when?***   * Yes * No * Unknown | | | |  | | | | | |
| *Currently suicidal?*   * Yes * No * Unknown | | | |  | | | | | |
| *Has your client received prior treatment from mental health services?* ***If yes, indicate below:***   * Yes * No * Unknown | | | |  | | | | | |
| ***Treatment Location: Treatment Date:*** | | | | **Describe:** | | | | | |
| *If any treatment program was NOT completed, please provide details:* | | | |  | | | | | |
|  | | | | | | | | | |
| **E. Social Functioning** | | | | | | | | | |
| *Is there any known history of sexual abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any known history of physical abuse?* | | | | | | | * Yes * No * Unknown | | |
| *Is there any history of family violence that the client may have been witness to?* | | | | | | | * Yes * No * Unknown | | |
| *Any self-harming behaviour(s)?* | | | | | | | * Yes * No * Unknown | | |
| Please indicate which (if any) of the following issues have been a part of your client’s family life and provide pertinent details in the associated space: | | | | | | | | | |
| * Sexually aggressive behaviors or promiscuity (verbal or physical) * Uncontrollable outburst of anger * Suicidal ideation * Self-harm or mutilation * Physical aggressive, abusive, or threatening behaviors * Verbally aggressive abusive, or threatening behaviors * Depression * Suicidal attempts   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Recklessness/unhealthy risk taking * Co-dependent/controlling * ADHD (Attention Deficit Hyperactivity Disorder) * Running away * Severe and debilitating anxiety * Eating disorder   ***Please specify details and dates:***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| * Mental Disorder * Difficulty following rules or regulations * Substance withdrawal (detoxification) * Other destructive behaviours (i.e., vandalism, arson) * FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) * Intellectual Development Disability * Dislike of or disregard for the authority figures * Medical complications that may affect treatment | | | | | | | | | |
| *Does your client go to school?*   * Yes * No * Unknown | | | | *Child Welfare Involvement?*   * Yes * No * Unknown | | | | | |
|  | | | | | | | | | |
| **H. Historical Trauma Event** | | | | | | | | | |
| *Has your client experienced historical trauma?* | | | | | | | | * Yes * No * Unknown | |
| *What kind of historical trauma has your client experienced?*   * Attended residential school * Experienced trauma in residential school * Experienced physical abuse (not residential school) * Experienced emotional abuse (not residential school) * Experienced sexual abuse (not residential school) * Experienced multiple foster care placements * Experienced trauma in foster care * Was separated from parents/family for other reasons * A family member/friend attempted suicide in the past year * Experienced natural death of a family/friend in the past year * Experienced death of a family member/friend in the past year * Experienced multiple deaths in my community in the past year * Experienced disaster/crisis in my community in the past year * Parent(s) attended residential school * Grandparent(s) attended residential school * Child abuse * Intergenerational trauma * Relocation * PTSD * Sixties Scoop Survivor * Foster Placement * Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |