

NNADAP/YSAC Family Intake & Referral Application

Child / Dependent

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: (MM/DD/YYYY) _____

Date Application Received by Treatment Centre: (MM/DD/YYYY) _____

Name of the referral worker/agency: _____

Phone number: _____

A. Client Information

Surname:

Language Understood:

First Name:

Status Indian:

Nickname/other name known by:

Treaty Number:

Date of Birth:

Band Name:

Age:

Other Indigenous Status:

Sex:

Relationship Status:

Health Card Number:

Emergency Contact:

Health Card Expiry Date:

Next of Kin:

Client Address:

Relationship to Next of Kin:

Client Phone:

Phone number of Next of Kin:

Language Spoken:

Language Preferred:

Gender:

- Female/Woman
- Male/Man
- Transgender
- Intersex
- Two-Spirited
- Gender Fluid
- No category describes me
- Decline to state
- Unknown

Living Situation:

- | | | |
|--------------------------------------|-------------------------------------------|------------------------------------------|
| <input type="checkbox"/> On-reserve | <input type="checkbox"/> Off-reserve | <input type="checkbox"/> Urban |
| <input type="checkbox"/> Rural | <input type="checkbox"/> Immediate Family | <input type="checkbox"/> Extended Family |
| <input type="checkbox"/> Lives Alone | <input type="checkbox"/> Homeless | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Foster Care | <input type="checkbox"/> Common Law |
| <input type="checkbox"/> Friend | | |
| <input type="checkbox"/> Unknown | | |

Custody Information:

- 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)

Social Worker Name/Contact Information:

B. Education and Social Status

<i>Grade Level</i>	<i>Has an Individual Education Plan</i>	<i>Has an Academic Assessment</i>	<i>Has Received Guidance Counselling</i>	<i>Has been previously apprehended</i>	<i>Has received a Behavior Assessment</i>
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
	Unknown	Unknown	Unknown	Unknown	Unknown

C. Legal Status

Has your client ever been in trouble with the law? Yes No

If yes, please explain: _____

Is your client under any of these legal involvements?

- | | | | |
|----------------------------------------------|-----------------------------------------|-----------------------------------------------|------------------------------------|
| <input type="checkbox"/> Criminal Court | <input type="checkbox"/> Family Court | <input type="checkbox"/> Drug Court Treatment | <input type="checkbox"/> Probation |
| <input type="checkbox"/> Charges Pending | <input type="checkbox"/> Court Referral | <input type="checkbox"/> Court Order | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Restorative Justice | <input type="checkbox"/> No Involvement | | |

Gang Involvement: Yes No

Is your client involved in any of the following legal conditions?

- | | | | |
|-------------------------------|---------------------------------|--------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Bail | <input type="checkbox"/> Parole | <input type="checkbox"/> Temporary Absence | <input type="checkbox"/> No Involvement |
|-------------------------------|---------------------------------|--------------------------------------------|-----------------------------------------|

If other, please specify: _____

Was alcohol or any other substances; such as 'sniff' or other drugs involved in your client's legal dealing?

- | | | | |
|------------------------------|-----------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Other |
|------------------------------|-----------------------------|----------------------------------|--------------------------------|

If other, please specify: _____

Is your client seeking treatment as a result of a court order or family service order?

- | | | |
|------------------------------|-----------------------------|----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
|------------------------------|-----------------------------|----------------------------------|

If yes, please explain: _____

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? _____

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

If yes, please explain: _____

<i>Treatment Location</i>	<i>Treatment Date</i>	<i>Describe</i>

Substance misuse for last year: _____

Has your client used substances for the last year? _____

If yes, complete a DUSI-R Assessment

E. Withdrawal Symptoms

Has your client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

<i>Symptoms</i>	<i>Describe</i>
<i>Blackouts</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>Hallucinations</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>Nausea/Vomiting</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>Seizures</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>Shakes</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>Delirium Tremens (DTs)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>Ever experienced DTs?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

F. Mental Health History

Provide the following information about the client's mental health status:

<i>Mental Illness</i>	<i>Describe</i>
<p><i>Been diagnosed with a mental illness</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Currently being treated</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Currently on psychiatric medication</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Taking medication consistently</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Eating (obesity, anorexia, bulimia, etc.)</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Sex (promiscuity, etc.)</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Internet / texting</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Gaming (video games and APP games)</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Has your client ever spoken or written about killing themselves?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Previous suicide attempts/ideations? If yes, please explain how and when:</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Hospitalized for suicide attempts? If yes, when?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	

<p><i>Currently suicidal?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Has your client received prior treatment from mental health services? If yes, indicate below:</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Treatment Location:</i> <i>Treatment Date:</i></p>	
<p><i>If any treatment program was NOT completed, please provide details:</i></p>	

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.

- | | |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Physically aggressive, abusive, or threatening behaviors | <input type="checkbox"/> Sexually aggressive behaviors or promiscuity (verbal or physical) |
| <input type="checkbox"/> Verbally aggressive abusive, or threatening behaviors | <input type="checkbox"/> Uncontrollable outbursts of anger |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal ideation |
| <input type="checkbox"/> Suicidal attempts | <input type="checkbox"/> Self-harm or mutilation |

Please specify details and dates:

- | | |
|----------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Running away | <input type="checkbox"/> Recklessness/unhealthy risk taking |
| <input type="checkbox"/> Severe and debilitating anxiety | <input type="checkbox"/> Co-dependent/controlling |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> ADHD (Attention Deficit Hyperactivity Disorder) |

Please specify details and dates:

- | | |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Intellectual Development Disability | <input type="checkbox"/> Difficulty following rules or regulations |
| <input type="checkbox"/> Dislike of or disregard for the authority figures | <input type="checkbox"/> Substance withdrawal (detoxification) |
| <input type="checkbox"/> Medical complications that may affect treatment | <input type="checkbox"/> Other destructive behaviors (ie. vandalism, arson) |

Does your client go to school?

- Yes No

Child Welfare Involvement?

- Yes No Unknown

H. Historical Trauma Event

Has your client experienced historical trauma? Yes No Unknown

What kind of historical trauma did your client experience?

- 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 trauma in foster care
- Experienced multiple foster care placements
- 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: _____