

Primary Participant

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

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: Female/Woman Gender Fluid Male/Man No category Transgender describes me Intersex Unknown Two-Spirited Decline to State	Client Address:		Client Phone:			
Language Spoken: English French	Language Pref	erred:	Language Understood:			
Nation Status: ☐ First Nation Non-Status ☐ Recog ☐ First Nation Status ☐ Métis	ınized Inuit	Treaty Number:				
☐ Inuit Non-Status ☐ Client for Sta	Not Elidigable atus	Band Name:				
Other Indigenous Status:		Relationship Status:				
Emergency Contact Name:		Emergency Contact Re	elationship:			
Emergency Contact Phone Number:		Next of Kin:				
Relationship to Next of Kin:		Next of Kin Phone:				
 □ 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 A Government) Disability Employment Income	Insurance (EI) None			
Employment Status: Self-Employed Full Time Seasonal Part Time Student Disability Assistance Retired Homemaker	Full Time Emplo Part Time Seas Unemployed Worker's Comp Student Other	onal □ Full Time □ Social A				

Living Situation: On-reserve Off-reserve Urban Rural Immediate Family Extended Family Homele Group H Group H Group H Commo	Home Care
☐ Lives Alone ☐ Unknow	'n
Is this family receiving any additional supports fro	m Jordan's Principle Programs?
	☐ Yes ☐ No ☐ Unsure
If yes, please describe:	
B. Legal Status	
Has your client ever been in trouble with the law?	☐ Yes ☐ No ☐ Unknown
If yes, please explain:	
	La the effect of the fellowing land and this end
Is your client under any of these legal involvements? Criminal Court Family Court Drug Court Treatment Probation Charges Pending Court Referral Court Order Restorative Justice	Is the client under any of the following legal conditions? Bail Parole Temporary Absence Order No Involvement Unknown Other If other, please specify:
☐ No Involvement	in other, please speeny.
Unknown	
Gang Involvement: ☐ Yes ☐ No ☐ Unki	nown
Was alcohol or any other substances, such as 'sn	iff' or other drugs involved in your client's legal dealing?
☐ Yes☐ No☐ Other☐ Unknown	
Is your client seeking treatment as a result of a co	ourt order or family service order?
☐ Yes If yes, please explain: ☐ No ☐ Unknown	

C. Children							
Other children and	their child welf	fare status (Not a	ttending treatm	ent	immedia	tely):	
Name	Date of Birth	Provincial Health	Status #	Se		Custody Information	
		Number & Expiry Date					
					Female	☐ Customary Traditional	
					Male	☐ Adoption	
				Ιп	Other:	☐ Biological	
					Outcr.	☐ Kinship/Foster	
						☐ Recent Apprehension	
						☐ Voluntary Family	
						Services	
						Orders of SupervisionUnsupervised Visitation	
						☐ Continued Supervision	
						☐ Temporary Supervision	
						□ Voluntary Placement	
						Agreement	
						☐ Continuous Care	
						(Ongoing Family	
						Services)	
					Female	☐ Customary Traditional	
					Male	☐ Adoption	
					Other:	☐ Biological	
					Other.	☐ Kinship/Foster	
						Recent Apprehension	
						☐ Voluntary Family	
						Services	
						Orders of Supervision	
						Unsupervised Visitation	
						Continued SupervisionTemporary Supervision	
						☐ Voluntary Placement	
						Agreement	
						☐ Continuous Care	
						(Ongoing Family	
						Services)	
					Female	☐ Customary Traditional	
					Male	☐ Adoption	
					Other:	☐ Biological	
					Oulei.	☐ Kinship/Foster	
					· · · · · · · · · · · · · · · · · · ·	☐ Recent Apprehension	
						☐ Voluntary Family	
						Services	
						☐ Orders of Supervision	
						☐ Unsupervised Visitation	
		I	ĺ	1		☐ Continued Supervision	

										em Male)		Volur Agree Conti (Ong Servi	emen nuou oing l ces) omary tion gical	s Care Family / Traditional	1
		,	. ,										Volur Servi Orde Unsu Conti Temp Volur Agree Conti	ntary ces rs of pervinued porary tary cemen nuou	prehension Family Supervision sed Visitation Supervision Supervision Placement t s Care Family	1
Children's edu									nmed					T		
Child	Gra Lev			vidual cation		an demic essment	Gι	eceiv uidar	nce		pre	s bee vious orehe		a l	s received Behaviour sessment	
				i Yes No Unknown	_ n	res No Jnknown		Yes No	elling s knowr			Yes No Unkr	iown		Yes No Unknown	
			1	Yes No Unknown	□ 1	res No Jnknown		Yes No Unl	s knowr	n		Yes No Unkr	iown		Yes No Unknown	
			1	Yes No Unknown	□ 1 □ U	res No Jnknown			knowr	n		Yes No Unkr	iown		Yes No Unknown	
			□ 1	Yes No Unknown	□ 1	res No Jnknown		Yes No Unl		n		Yes No Unkr	iown		Yes No Unknown	
D Chamical	Hos	Lictor-	, c.	uhetanee	mic:	so prior	to t	troot	tmar	2	ict	or:				
At what age d	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 d	id yo	ur client s	start u	ising other (arugs	?										

Does anyone else in their family us	se solvents/substan	ces?					
□ Yes □ No							
☐ Unknown							
If yes, please specify:							
Has anyone in their family or comn	nunity received trea	tment for solvent	t/substance abuse?				
☐ Yes	idility received trea	unent for solvent	Journal and a substance and see				
□ No							
☐ Unknown If yes, please explain:							
, 900, produce on product							
Has client participated in a non-res	sidential/community-	-based substance	e abuse program?				
□ Yes □ No							
☐ Unknown							
If yes, please explain:							
Has your client received prior treat	ment at a residentia	al addiction centre	e?				
□ No							
□ Unknown							
If yes, please explain:							
Treatment Location	Treatment Date		Describe				
			(Completed/Not Completed?)				
Has your client used substances for	l or the last vear?						
	ine last year.	☐ Yes					
		□ No					
If you complete a DUCLE Assessed	omt.	☐ Unknown					
If yes, complete a DUSI-R Assessm	ent.						

Has the client attended a pre-treatment counselling session with you? ☐ Yes ☐ No ☐ Unknow	'n
□ No	'n
Has the client attended any withdrawal management prior to coming to the treatment Yes	
centre? □ No □ Unknow	(D
	111
If yes, please explain:	
F. With drawal Comptons	
F. Withdrawal Symptoms Has your client experienced any of the following symptoms while withdrawing from substances in the last	o t
6 months?	51
Symptoms Describe	
Blackouts	
☐ Yes	
□ No	
☐ Unknown Hallucinations	
☐ Yes	
□ No	
Unknown	
Nausea/Vomiting ☐ Yes	
□ No	
□ Unknown	
Seizures	
☐ Yes ☐ No	
☐ Unknown	
Shakes	
☐ Yes ☐ No	
□ 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 n	nental 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 two streets are around your NOT as well-to deal of the	
If any treatment program was NOT completed, please	provide details:

Has your prima management or	depression? Yes No	d in other programs/so	ervices i.e., Re	elationship counselling, anger			
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 cur	rently requesting treatme	nt (please comment o		nd participant strength):			
H. Social Fun	ctioning						
Is there any kno	wn history of sexual abu	se?		Yes			
				☐ No☐ Unknown			
Is there any kno	wn history of physical ab	☐ Yes					
_		□ No					
Is there any hist	ory of family violence tha	☐ Unknown ☐ Yes					
to?	,,	, ,		□ No			
Any self-harmin	a hehaviour(s)?			☐ Unknown ☐ Yes			
Any Sen-naming	g benaviour(s):			□ No			
Diagon indicate	which (if any) of the faller	ving incurs have been	a mont of volum	Unknown			
	which (if any) of the follow the details in the associated		i a part of your	client's family life and			
☐ Physical agg	ressive, abusive, or threate	ening behaviors	Sexually aggre	ssive behaviors or promiscuity			
	ressive abusive, or threater	ning behaviors	(verbal or phys	•			
☐ Depression	1.			outburst of anger			
☐ Suicidal atte	mpts		Suicidal ideatio Self-harm or m				
Please specify d	etails and dates:		Con Hairii Oi III	adiadon			

	Running away Severe and debilitating anxiety Eating disorder		Recklessness/unhealthy risk taking Co-dependent/controlling ADHD (Attention Deficit Hyperactivity Disorder)
Plea	se specify the eating disorder:		
	FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effectintellectual Development Disability	cts) 🗆	Mental Disorder Difficulty following rules or regulations
	Dislike of or disregard for the authority figures		Substance withdrawal (detoxification)
	Medical complications that may affect treatment		Other destructive behaviors (i.e., vandalism, arson)
Doe	s your client go to school?	Child V	Velfare Involvement?
l]	☐ Yes ☐ No		Yes No
[Unknown		Unknown
	istorical Trauma Event		
Has	your client experienced historical trauma?	Yes	
		No	
	L	Unkn	own
Wha	at kind of historical trauma has your client experie	nced? F	Please select.
[☐ Attended residential school		
[Experienced trauma in residential school		
[\square Experienced physical abuse (not residential se	chool)	
[☐ Experienced emotional abuse (not residential	school)	
[\square Experienced sexual abuse (not residential sch	nool)	
[☐ Experienced multiple foster care placements		
[☐ Experienced trauma in foster care		
[\square Was separated from parents/family for other re	easons	
[\square A family member/friend attempted suicide in the	he past ;	year
[\square Experienced natural death of a family/friend in	the pas	st year
[☐ Experienced death of a family member/friend	in the pa	ast year
[☐ Experienced multiple deaths in my community	/ in the p	past year
[☐ Experienced disaster/crisis in my community i	in the pa	st 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. Clie	ent'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	e list any questions or concerns the client has indicated during the intake process:



Spouse / Partner

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

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:	First Name:	
Nickname or other name known by:		Date of Birth:		
Health Card Number:	Health Card Expiry Date:	Age:	Sex: Female Male	
Gender: Female/Woman Gender Fluid Male/Man No category Transgender describes me Intersex Unknown Two-Spirited Decline to State	Client Address	:	Client Phone Number:	
Language Spoken:	Language Pref	erred:	Language Understood:	
Nation Status: ☐ First Nation Non-Status ☐ Recog ☐ First Nation Status ☐ Métis	nized Inuit	Treaty Number:		
☐ Inuit Non-Status ☐ Client Not Eligible for Status		Band Name:		
Other Indigenous Status:		Relationship Status:		
Emergency Contact Name:		Emergency Contact Re	elationship:	
Emergency Contact Phone Number:		Next of Kin:		
Relationship to Next of Kin:		Next of Kin Phone Nun	mber:	
 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 A Government) Disability Employment Income	Insurance (EI) ☐ None	
☐ Full Time Seasonal ☐ Part Time Student ☐ Disability Assistance ☐ Retired ☐	Full Time Emp Part Time Sea Unemployed Worker's Com Student Other	asonal □ Full Tir □ Social		

Living Situation: On-reserve Off-reserve	Jome Care n Law n		
If yes, please explain:	☐ Yes ☐ No ☐ Unknown		
Is your client under any of these legal involvements? 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 the following legal conditions? Bail Parole Temporary Absence Order No Involvement Unknown If other, please specify:			
Gang Involvement: ☐ Yes ☐ No ☐ Unknown			
Was alcohol or any other substances, such as 'sniff' or other drugs involved in your client's legal dealing? Yes If other, please specify: Other Unknown			
Is your client seeking treatment as a result of a court order or family service order? \(\text{Yes} \text{If yes, please explain:} \\ \(\text{No} \text{Unknown} \)			
C. Chamical Has History Substance misu			
C. Chemical Use History - Substance misu 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 us	se solvents/substances?	
□ No		
☐ Unknown		
If yes, please specify:		
│ Has anyone in their family or comn │ □ Yes	nunity received treatment for solven	t/substance abuse?
□ No		
☐ Unknown		
If yes, please explain:		
in you, product expression		
Has the client participated in a non	-residential/community-based subst	ance abuse program?
☐ Yes		omee and accipine gramm
□ No		
□ Unknown		
If yes, please explain:		
ii yee, piedee expidiii		
Has your client received prior treat	ment at a residential addiction centr	e?
□ Yes		
□ No		
□ Unknown		
Treatment Location	Treatment Date	Describe
		(Completed/Not Completed?)
Has your client used substances fo	or the last year?	
☐ Yes		
□ No		
□ Unknown	_	
	If yes, compl	lete a DUSI-R Assessment.

D. Pre-Treatment		
Has the client attended a pre-treatment counselling s	session with you?	☐ Yes
If yes, please explain:		☐ No ☐ Unknown
Has the client attended any withdrawal management	t prior to coming to the treatment	☐ Yes
centre?	phorico coming to the treatment	☐ No ☐ Unknown
If yes, please explain:		
E. Withdrawal Symptoms		
Has your client experienced any of the following sym	ptoms while withdrawing from substan	ces in the last
6 months?	1 =	
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		

Provide the following information about the client's mental health status:	F. Mental Health History	
Been diagnosed with a mental illness Yes Yes Unknown		nental health status:
Yes		Describe
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:		
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 suicida? 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:		
Yes No Unknown No Unknown Taking medication ocnsistently Yes No Unknown Unknown No Unknown Unkn		
□ 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 suicida? □ 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:		
Currently on psychiatric medication Yes		
Currently on psychiatric medication Yes		
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 Hospitalized for suicide attempts? If yes, when? Yes No Unknown Unknown Has your client received prior treatment from mental health services? If yes, indicate below: Yes No Unknown Treatment Location: Treatment Date: Describe:		
□ 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 Currently suicidal? □ Yes □ No □ Unknown Tas your client received prior treatment from mental health services? If yes, indicate below: □ Yes □ No □ Unknown Treatment Location: Treatment Date: Describe:		
□ 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: If any treatment program was NOT completed, please		
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 Unknown Currently suicidal? Yes No Unknown Has your client received prior treatment from mental health services? If yes, indicate below: Yes No Unknown Unknown Treatment Location: Treatment Date: Describe:		
Yes No Unknown		
Unknown Had your client ever spoken or written about killing themself?		
Had your client ever spoken or written about killing themself? Yes	□ No	
themself?	☐ Unknown	
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:		
Unknown Previous suicide attempts/ideations? If yes, please explain how and when:		
Previous suicide attempts/ideations? If yes, please explain how and when:		
explain how and when: Yes		
Yes No Unknown	Previous suicide attempts/ideations? If yes, please	
□ 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:		
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:		
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:		
☐ 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: If any treatment program was NOT completed, please		
□ 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: If any treatment program was NOT completed, please		
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:		
□ 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	□ Unknown	
□ No □ Unknown Has your client received prior treatment from mental health services? If yes, indicate below: □ Yes □ No □ Unknown Treatment Location: Treatment Date: Describe:	Currently suicidal?	
□ Unknown Has your client received prior treatment from mental health services? If yes, indicate below: □ Yes □ No □ Unknown Treatment Location: Treatment Date: Describe:	□ Yes	
Has your client received prior treatment from mental health services? If yes, indicate below: Yes No Unknown Treatment Location: Treatment Date: Describe:	□ No	
health services? If yes, indicate below: Yes No Unknown Treatment Location: Treatment Date: Describe:		
☐ Yes ☐ No ☐ Unknown Treatment Location: Treatment Date: Describe: If any treatment program was NOT completed, please		
□ No □ Unknown Treatment Location: Treatment Date: Describe: If any treatment program was NOT completed, please		
Treatment Location: Treatment Date: Describe: If any treatment program was NOT completed, please		
Treatment Location: Treatment Date: Describe: If any treatment program was NOT completed, please		
If any treatment program was NOT completed, please		Describe
If any treatment program was NOT completed, please provide details:	Treatment Location: Treatment Date:	Describe:
If any treatment program was NOT completed, please provide details:		
If any treatment program was NOT completed, please provide details:		
If any treatment program was NOT completed, please provide details:		
provide details:	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 to?	have been witness ☐ Yes ☐ No ☐ Unknown
Any self-harming behaviour(s)?	☐ Yes ☐ No ☐ Unknown
Please indicate which (if any) of the following issues have provide pertinent details in the associated space:	e been a part of your client's family life and
 □ Physical aggressive, abusive, or threatening behaviours □ Verbally aggressive, abusive, or threatening behaviours □ Depression □ Suicidal attempts 	 Sexually aggressive behaviours or promiscuity (verbal or physical) Uncontrollable outburst of anger Suicidal ideation Self-harm or mutilation
Please specify details and dates:	
☐ Running away☐ Severe and debilitating anxiety☐ Eating disorder	 ☐ Recklessness/unhealthy risk taking ☐ Co-dependent/controlling ☐ ADHD (Attention Deficit Hyperactivity Disorder)
Please specify details and dates:	
 □ 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 	 □ Mental Disorder □ Difficulty following rules or regulations □ Substance withdrawal (detoxification) □ Other destructive behaviours (i.e., vandalism, arson)
Does your client go to school? ☐ Yes ☐ No ☐ Unknown	ild Welfare Involvement? ☐ Yes ☐ No ☐ Unknown
H. Historical Trauma Event	· -
Has your client experienced historical trauma?	☐ Yes ☐ No ☐ Unknown

What I	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:



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.

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:	First Name:	
Nickname or other name known by:		Date of Birth:	Date of Birth:	
Health Card Number:	Health Card Expiry Date:	Age:	Sex: Female Male	
Gender: Female/Woman	Client Address		Client Phone:	
Language Spoken: ☐ English ☐ French	Language Pref	erred:	Language Understood:	
	nized Inuit	Treaty Number:	Treaty Number:	
	Not Eligible tus	Band Name:		
Other Indigenous Status:		Relationship Status:		
Emergency Contact Name:		Emergency Contact R	elationship:	
Emergency Contact Phone Number:		Next of Kin:		
Relationship to Next of Kin:		Next of Kin Phone Nu	mber:	
Education: Less than grade 8 Completed high school Not completed high school Completed post-secondary Some post-secondary		Literacy Level: Illiterate Literate Needs assistance		
Living Situation: On-reserve Off-reserve Urban Rural Immediate Family Extended Family Lives Alone	☐ Homeles ☐ Group H ☐ Shelter ☐ Foster C ☐ Commor ☐ Friend ☐ Unknow	care n Law		

Custody Information	on:				
-		□ Orders of Su	nervision		
	☐ Customary Traditional				
	Adoption		Unsupervise		
	Biological		☐ Continued Su	•	
	Kinship/Foster		☐ Temporary S	upervision	
	Recent Apprehen	sion	☐ Voluntary Pla	cement Agreement	
	Voluntary Family			Care (Ongoing Fami	
					ily oct vices)
Social Worker Na	ame and Contact I	nformation:			
	and Social Statu	,	1		
Grade Level	Has an	Has an	Has Received	Has been	Has received a
	Individual	Academic	Guidance	previously	Behaviour
	Education Plan	Assessment	Counselling	apprehended	Assessment
	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
	□ No	□ No	□ No	□ No	□ No
	☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown
C Chamical II	an History Cul	ostanoo miayaa	prior to trootme	nt history	
			prior to treatme		
	neir tamily or comn	nunity received tre	eatment for solvent	substance abuse	?
☐ Yes					
□ No					
☐ Unknown					
If yes, please explain:					
Has your client n	participated in a no	n_residential/com	munity-based subs	tance abuse prog	ram?
Tras your cherit p	articipateu iri a rio	II-IESIUEIIIIAI/COIIII	nunity-based subs	tance abuse prog	iaiii:
□ No					
☐ Unknown					
If yes, please exp	olain:				
Has your client r	eceived prior treat	ment at a resident	rial addiction centre	2	
☐ Yes	eceived prior treati	illelli al a l'esidelli	iai addiction centre	7 :	
☐ No					
☐ Unknown					
If yes, please exp	olain:				
• • •					
Treatment Loca	ation	Treatment Date		Describe	
i i i calificiil LUCA	ILIOII	i i calinelil Dale	;	Desci inc	

			(Completed/Not Completed?)
Has your client used substances for	the last year?		
-	•	☐ Yes	
		□ No	
		Unknown	
		□ OHKHOWH	
If yes, complete a DUSI-R Assessme	nt.		
D. Mental Health History			
Provide the following information abo	out the client's me	ental health status	S.
Mental Illness	out the elicites the	Describe	J.
Been diagnosed with a mental illness		Describe	
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 a	bout killing		
themself?			
☐ Yes			
□ No			
□ Unknown			

	T
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:
10.7	
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
γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ	□ No
	☐ Unknown
Is there any history of family violence that the client n	nav have been witness 🔲 Yes
to?	No
	☐ Unknown
Any self-harming behaviour(s)?	☐ Yes
3 11 1 (2)	□ No
	☐ Unknown
Please indicate which (if any) of the following issues	
provide pertinent details in the associated space:	p y 22y
 Physical aggressive, abusive, or threatening behavior 	, , , , , , , , , , , , , , , , , , , ,
 Verbally aggressive abusive, or threatening behaviors 	s (verbal or physical)
□ Depression	☐ Uncontrollable outburst of anger
☐ Suicidal attempts	☐ Suicidal ideation
	Self-harm or mutilation
	Johniann of Mulialion

Please specify details and dates:				
 □ Running away □ Severe and debilitating anxiety □ Eating disorder Please specify details and dates:	 □ Recklessness/unhealthy risk taking □ Co-dependent/controlling □ ADHD (Attention Deficit Hyperactivity Disorder) 	der)		
——————————————————————————————————————				
 □ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effect □ Intellectual Development Disability □ Dislike of or disregard for the authority figures □ Medical complications that may affect treatment 	 Mental Disorder Difficulty following rules or regulations Substance withdrawal (detoxification) Other destructive behaviours (i.e., vandalis arson) 	m,		
Does your client go to school? Yes	Child Welfare Involvement? ☐ Yes			
□ No	□ No			
☐ Unknown	☐ Unknown			
H. Historical Trauma Event				
Has your client experienced historical trauma?	☐ Yes ☐ No ☐ Unknown			
What kind of historical trauma has your client experier	ced?			
☐ Attended residential school				
 Experienced trauma in residential school 				
$\ \square$ Experienced physical abuse (not residential sc	☐ Experienced physical abuse (not residential school)			
$\ \square$ Experienced emotional abuse (not residential s	☐ 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				
$\ \square$ A family member/friend attempted suicide in the past year				
☐ Experienced natural death of a family/friend in the past year				
\square 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:



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.

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 Gender Fluid Male/Man No category Gescribes me Intersex Unknown Two-Spirited Decline to State	Client Address		Client Phone:	
Language Spoken: ☐ English ☐ French	Language Pref	erred:	Language Understood:	
☐ First Nation Status ☐ Métis	nized Inuit Not Eligible tus	Treaty Number: Band Name:		
Other Indigenous Status:		Relationship Status:		
Emergency Contact Name:		Emergency Contact Re	elationship:	
Emergency Contact Phone Number:		Next of Kin:		
Relationship to Next of Kin:		Next of Kin Phone Nun	nber:	
Education: Less than grade 8 Completed high school Not completed high school Completed post-secondary Some post-secondary		Literacy Level: Illiterate Literate Needs assistance		

Living Situation:	Off-reserve Urban Rural Immediate Family Extended Family Lives Alone	☐ Homeless ☐ Group Home ☐ Shelter ☐ Foster Care ☐ Common Lar ☐ Friend ☐ Unknown			
		sion		d Visitation ipervision	y Services)
Social Worker Na	ame and Contact I	nformation:			
D. E. L					
	nd Social Statu	s Has an	Has Received	Has been	Has received a
Grade Level	Has an Individual Education Plan	Academic Assessment	Guidance Counselling	previously apprehended	Behaviour Assessment
	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
			prior to treatme		-
Has anyone in their family or community received treatment for solvent/substance abuse? Yes No Unknown If yes, please explain:					
Has your client p ☐ Yes ☐ No ☐ Unknown	articipated in a no	n-residential/comn	nunity-based subs	tance abuse progr	am?
If yes, please exp	lain:				
Has your client re	eceived prior treati	ment at a residenti	ial addiction centre	?	

□ Yes			
□ No			
☐ Unknown			
If yes, please explain:			
Treatment Location	Treatment Date		Describe
			(Completed/Not Completed?)
			(Completed in placed in)
Has your client used substances fo	r the last year?	_	
		☐ Yes	
		□ No	
		☐ Unknown	
If yes, complete a DUSI-R Assessme	ent.		
D. Mental Health History			
Provide the following information all	bout the client's me	ental health status	S.
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	. 1		
Gaming (video games and APP games	5 <i>)</i>		

·		
☐ 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:	
Troutment 200ation	500011501	
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
In the one consideration of the second secon		Unknown
Is there any history of family violence that the client m	ay nave been witness	☐ Yes
to?		☐ No ☐ Unknown
Any self-harming behaviour(s)?		☐ Yes
Any sell-hallfillig beliaviour(s)!		☐ No
		□ Unknown
		JIIIII VIII

Please indicate which (if any) of the following issues he provide pertinent details in the associated space:	nave been a part of your client's family life and			
 □ Physical aggressive, abusive, or threatening behaviors □ Verbally aggressive abusive, or threatening behaviors □ Depression □ Suicidal attempts 				
Please specify details and dates:				
 ☐ Running away ☐ Severe and debilitating anxiety ☐ Eating disorder Please specify details and dates:	 □ Recklessness/unhealthy risk taking □ Co-dependent/controlling □ ADHD (Attention Deficit Hyperactivity Disorder) 			
 □ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effection □ Intellectual Development Disability □ Dislike of or disregard for the authority figures □ Medical complications that may affect treatment 	 Mental Disorder Difficulty following rules or regulations Substance withdrawal (detoxification) Other destructive behaviours (i.e., vandalism, arson) 			
Does your client go to school? ☐ Yes	Child Welfare Involvement? ☐ Yes			
□ No	□ No			
□ Unknown	□ Unknown			
H. Historical Trauma Event				
Has your client experienced historical trauma?	☐ Yes☐ No☐ Unknown			
What kind of historical trauma has your client experien	nced?			
☐ Attended residential school				
☐ Experienced trauma in residential school				
☐ Experienced physical abuse (not residential school)				
☐ Experienced emotional abuse (not residential school)				
$\ \square$ Experienced sexual abuse (not residential sch	iool)			
☐ 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:



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.

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: Female/Woman Gender Fluid Male/Man No category Transgender describes me Intersex Unknown Two-Spirited Decline to State	Client Address:		Client Phone:
Language Spoken: ☐ English ☐ French	Language Pref	erred:	Language Understood:
Nation Status: ☐ First Nation Non-Status ☐ Recog ☐ First Nation Status ☐ Métis	nized Inuit	Treaty Number:	
☐ Inuit Non-Status ☐ Client for Sta	Not Eligible tus	Band Name:	
Other Indigenous Status:		Relationship Status:	
Emergency Contact Name:		Emergency Contact Ro	elationship:
Emergency Contact Phone Number:		Next of Kin:	
Relationship to Next of Kin:		Next of Kin Phone Nur	mber:
Education: Less than grade 8 Completed high school Not completed high school Completed post-secondary Some post-secondary		Literacy Level:	
Living Situation: On-reserve Off-reserve Urban Rural Immediate Family Extended Family Lives Alone	☐ Homeles☐ Group H☐ Shelter☐ Foster C☐ Commor☐ Friend☐ Unknown	ome are n Law	

Custody Information:						
☐ Customary Traditional			Orders of Su	pervision		
☐ Adoption		☐ Unsupervised Visitation				
			☐ Continued S			
	Kinship/Foster		☐ Temporary S			
	•	_!	•	acement Agreement		
	Recent Apprehen			-		
	Voluntary Family	Services	□ Continuous (Care (Ongoing Fami	ly Services)	
Social Worker Na	ame and Contact I	nformation:				
B. Education a	nd Social Statu	S				
Grade Level	Has an	Has an	Has Received	Has been	Has received a	
	Individual	Academic	Guidance	previously	Behaviour	
	Education Plan	Assessment	Counselling	apprehended	Assessment	
	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
	□ No	□ No	□ No	□ No	□ No	
			☐ Unknown		☐ Unknown	
	Unknown	Unknown	Unknown	☐ Unknown	Unknown	
	se History - <i>Sub</i>					
Has anyone in their family or community received treatment for solvent/substance abuse? Yes No Unknown If yes, please explain:						
	articipated in a no	n-residential/comr	nunity-based subs	stance abuse prog	ram?	
☐ Yes						
	□ No					
☐ Unknown						
If yes, please explain:						
Has your client received prior treatment at a residential addiction centre?						
☐ Yes						
□ No						
☐ Unknown	□ Unknown					
If yes, please explain:						
Treatment Loca	tion	Treatment Date		Describe		

			(Completed/Not Completed?)
Has your client used substances for	the last year?		
-	•	☐ Yes	
		□ No	
		Unknown	
		□ OHKHOWH	
If yes, complete a DUSI-R Assessme	nt.		
D. Mental Health History			
Provide the following information abo	out the client's me	ental health status	S.
Mental Illness	out the elicites the	Describe	J.
Been diagnosed with a mental illness		Describe	
Yes			
□ No			
☐ Unknown			
Currently being treated			
□ 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 a	bout 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	B "
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 m	
to?	□ No
Any only beginning to be a single (a)	Unknown
Any self-harming behaviour(s)?	☐ Yes ☐ No
	☐ Unknown
Please indicate which (if any) of the following issues h	
Please indicate which (if any) of the following issues h	lave been a part of your cliefft's family life and
provide pertinent details in the associated space:	
 Physical aggressive, abusive, or threatening behavior 	s
☐ Verbally aggressive abusive, or threatening behaviors	
□ Depression	☐ Uncontrollable outburst of anger
☐ Suicidal attempts	☐ Suicidal ideation
_ Caloradi attorripto	Self-harm or mutilation

Please specify details and dates:				
 □ Running away □ Severe and debilitating anxiety □ Eating disorder Please specify details and dates:	 □ Recklessness/unhealthy risk taking □ Co-dependent/controlling □ ADHD (Attention Deficit Hyperactivity Disorder) 	der)		
——————————————————————————————————————				
 □ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effect □ Intellectual Development Disability □ Dislike of or disregard for the authority figures □ Medical complications that may affect treatment 	 Mental Disorder Difficulty following rules or regulations Substance withdrawal (detoxification) Other destructive behaviours (i.e., vandalis arson) 	m,		
Does your client go to school? Yes	Child Welfare Involvement? ☐ Yes			
□ No	□ No			
☐ Unknown	☐ Unknown			
H. Historical Trauma Event				
Has your client experienced historical trauma?	☐ Yes ☐ No ☐ Unknown			
What kind of historical trauma has your client experier	ced?			
☐ Attended residential school				
 Experienced trauma in 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				
\square Was separated from parents/family for other reasons				
$\ \square$ A family member/friend attempted suicide in th	e past year			
\square Experienced natural death of a family/friend in the past year				
\square 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: Female/Woman	Client Address		Client Phone:		
Language Spoken: ☐ English ☐ French	Language Pref	erred:	Language Understood:		
	nized Inuit	Treaty Number:			
	Not Eligible tus	Band Name:			
Other Indigenous Status:		Relationship Status:			
Emergency Contact Name:		Emergency Contact R	elationship:		
Emergency Contact Phone Number:		Next of Kin:			
Relationship to Next of Kin:		Next of Kin Phone Nu	mber:		
Education: Less than grade 8 Completed high school Not completed high school Completed post-secondary Some post-secondary		Literacy Level: Illiterate Literate Needs assistance			
Living Situation: On-reserve Off-reserve Urban Rural Immediate Family Extended Family Lives Alone	☐ Homeles ☐ Group H ☐ Shelter ☐ Foster C ☐ Commor ☐ Friend ☐ Unknow	care n Law			

Custody Information	on:				
	Customary Traditi	onal	□ Orders of Su	nervision	
	•	Ullai			
	Adoption		Unsupervise		
	Biological		☐ Continued Su	•	
	Kinship/Foster		☐ Temporary S	upervision	
	Recent Apprehen	sion	☐ Voluntary Pla	cement Agreement	
	Voluntary Family			Care (Ongoing Fami	
					ily oct vices)
Social Worker Na	ame and Contact I	nformation:			
	and Social Statu	,	1		
Grade Level	Has an	Has an	Has Received	Has been	Has received a
	Individual	Academic	Guidance	previously	Behaviour
	Education Plan	Assessment	Counselling	apprehended	Assessment
	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
	□ No	□ No	□ No	□ No	□ No
	☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown
C Chamical II	an History Cul	ostanoo miayaa	prior to trootme	nt history	
			prior to treatme		
	neir tamily or comn	nunity received tre	eatment for solvent	substance abuse	?
☐ Yes					
\square No					
☐ Unknown					
If yes, please explain:					
Has your client n	participated in a no	n_residential/com	munity-based subs	tance abuse prog	ram?
Tras your cherit p	articipateu iri a rio	II-IESIUEIIIIAI/COIIII	nunity-based subs	tance abuse prog	iaiii:
□ No					
☐ Unknown					
If yes, please exp	olain:				
Has your client r	eceived prior treat	ment at a resident	rial addiction centre	2	
☐ Yes	eceived prior treati	illelli al a l'esidelli	iai addiction centre	7 :	
☐ No					
☐ Unknown					
If yes, please exp	olain:				
• • •					
Treatment Loca	ation	Treatment Date		Describe	
i i i calificiil LUCA	ILIOII	i i calinelil Dale	;	Desci inc	

			(Completed/Not Completed?)
Has your client used substances for	the last year?		
-	•	☐ Yes	
		□ No	
		Unknown	
		□ OHKHOWH	
If yes, complete a DUSI-R Assessme	nt.		
D. Mental Health History			
Provide the following information abo	out the client's me	ental health status	S.
Mental Illness	out the elicites the	Describe	J.
Been diagnosed with a mental illness		Describe	
Yes			
□ No			
☐ Unknown			
Currently being treated			
□ 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 a	bout killing		
themself?			
☐ Yes			
□ No			
□ Unknown			

	T
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:
10.7	
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
γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ	□ No
	☐ Unknown
Is there any history of family violence that the client n	nav have been witness 🔲 Yes
to?	No
	☐ Unknown
Any self-harming behaviour(s)?	☐ Yes
3 11 1 (2)	□ No
	☐ Unknown
Please indicate which (if any) of the following issues	
provide pertinent details in the associated space:	p y 22y
 Physical aggressive, abusive, or threatening behavior 	, , , , , , , , , , , , , , , , , , , ,
 Verbally aggressive abusive, or threatening behaviors 	s (verbal or physical)
□ Depression	☐ Uncontrollable outburst of anger
☐ Suicidal attempts	☐ Suicidal ideation
	Self-harm or mutilation
	Johniann of Mulialion

Please specify details and dates:				
 □ Running away □ Severe and debilitating anxiety □ Eating disorder Please specify details and dates:	 □ Recklessness/unhealthy risk taking □ Co-dependent/controlling □ ADHD (Attention Deficit Hyperactivity Disorder) 	der)		
——————————————————————————————————————				
 □ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effect □ Intellectual Development Disability □ Dislike of or disregard for the authority figures □ Medical complications that may affect treatment 	 Mental Disorder Difficulty following rules or regulations Substance withdrawal (detoxification) Other destructive behaviours (i.e., vandalis arson) 	m,		
Does your client go to school? Yes	Child Welfare Involvement? ☐ Yes			
□ No	□ No			
☐ Unknown	☐ Unknown			
H. Historical Trauma Event				
Has your client experienced historical trauma?	☐ Yes ☐ No ☐ Unknown			
What kind of historical trauma has your client experier	ced?			
☐ Attended residential school				
 Experienced trauma in 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				
\square Was separated from parents/family for other reasons				
$\ \square$ A family member/friend attempted suicide in th	e past year			
\square Experienced natural death of a family/friend in the past year				
\square 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: Female/Woman	Client Address		Client Phone:
Language Spoken: ☐ English ☐ French	Language Pref	erred:	Language Understood:
	nized Inuit	Treaty Number:	
	Not Eligible tus	Band Name:	
Other Indigenous Status:		Relationship Status:	
Emergency Contact Name:		Emergency Contact R	elationship:
Emergency Contact Phone Number:		Next of Kin:	
Relationship to Next of Kin:		Next of Kin Phone Nu	mber:
Education: Less than grade 8 Completed high school Not completed high school Completed post-secondary Some post-secondary		Literacy Level: Illiterate Literate Needs assistance	
Living Situation: On-reserve Off-reserve Urban Rural Immediate Family Extended Family Lives Alone	☐ Homeles ☐ Group H ☐ Shelter ☐ Foster C ☐ Commor ☐ Friend ☐ Unknow	care n Law	

Custody Information	on:					
	Customary Traditi	onal	Orders of Su	pervision		
			☐ Unsupervised Visitation			
			☐ Continued S			
	Kinship/Foster		☐ Temporary S			
	•	_!	•	acement Agreement		
	Recent Apprehen			-		
	Voluntary Family	Services	□ Continuous (Care (Ongoing Fami	ly Services)	
Social Worker Na	ame and Contact I	nformation:				
B. Education a	nd Social Statu	S				
Grade Level	Has an	Has an	Has Received	Has been	Has received a	
	Individual	Academic	Guidance	previously	Behaviour	
	Education Plan	Assessment	Counselling	apprehended	Assessment	
	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
	□ No	□ No	□ No	□ No	□ No	
			☐ Unknown		☐ Unknown	
	Unknown	Unknown	Unknown	☐ Unknown	Unknown	
	se History - <i>Sub</i>					
☐ Yes☐ No☐ Unknown If yes, please exp	lain:	·		/substance abuse		
	articipated in a no	n-residential/comr	nunity-based subs	stance abuse prog	ram?	
☐ Yes						
□ No						
☐ Unknown						
If yes, please exp	lain:					
	eceived prior treati	ment at a resident	ial addiction centre	e?		
☐ Yes						
□ No						
☐ Unknown						
If yes, please exp	lain:					
Treatment Loca	tion	Treatment Date		Describe		

			(Completed/Not Completed?)
Has your client used substances for	the last year?		
-	•	☐ Yes	
		□ No	
		Unknown	
		□ OHKHOWH	
If yes, complete a DUSI-R Assessme	nt.		
D. Mental Health History			
Provide the following information abo	out the client's me	ental health status	S.
Mental Illness	out the elicites the	Describe	J.
Been diagnosed with a mental illness		Describe	
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 a	bout 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
To those daily surcess, success, or projection distances.	□ No
	☐ Unknown
Is there any history of family violence that the client n	
to?	□ No
10:	☐ Unknown
Any self-harming behaviour(s)?	☐ Yes
This con training behavious (e):	□ No
	☐ Unknown
Please indicate which (if any) of the following issues I	
provide pertinent details in the associated space:	14.0 2001 a part of your ononto farming into and
 Physical aggressive, abusive, or threatening behavior 	s
☐ Verbally aggressive abusive, or threatening behaviors	(verbal or physical)
☐ Depression	☐ Uncontrollable outburst of anger
·	☐ Suicidal ideation
☐ Suicidal attempts	
	Self-harm or mutilation

Please specify details and dates:				
☐ Running away☐ Severe and debilitating anxiety☐ Eating disorder		Recklessness/unhealthy risk taking Co-dependent/controlling ADHD (Attention Deficit Hyperactivity Disorder)		
Please specify details and dates:				
 □ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effection □ Intellectual Development Disability □ Dislike of or disregard for the authority figures □ Medical complications that may affect treatment 	cts) 🗆	Mental Disorder Difficulty following rules or regulations Substance withdrawal (detoxification) Other destructive behaviours (i.e., vandalism, arson)		
Does your client go to school? Yes	_	Velfare Involvement? Yes		
□ No		No		
□ Unknown		Unknown		
H. Historical Trauma Event				
Has your client experienced historical trauma?		☐ Yes ☐ No ☐ Unknown		
What kind of historical trauma has your client experie	nced?			
☐ Attended residential school				
☐ Experienced trauma in residential school				
$\ \square$ Experienced physical abuse (not residential so	☐ Experienced physical abuse (not residential school)			
☐ Experienced emotional abuse (not residential school)				
☐ Experienced sexual abuse (not residential school)				
☐ Experienced multiple foster care placements	☐ Experienced multiple foster care placements			
 Experienced trauma in foster care 	☐ Experienced trauma in foster care			
$\ \square$ Was separated from parents/family for other re	☐ 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 pa	ast 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: Female/Woman	Client Address		Client Phone:
Language Spoken: ☐ English ☐ French	Language Pref	erred:	Language Understood:
	nized Inuit	Treaty Number:	
	Not Eligible tus	Band Name:	
Other Indigenous Status:		Relationship Status:	
Emergency Contact Name:		Emergency Contact R	elationship:
Emergency Contact Phone Number:		Next of Kin:	
Relationship to Next of Kin:		Next of Kin Phone Nu	mber:
Education: Less than grade 8 Completed high school Not completed high school Completed post-secondary Some post-secondary		Literacy Level: Illiterate Literate Needs assistance	
Living Situation: On-reserve Off-reserve Urban Rural Immediate Family Extended Family Lives Alone	☐ Homeles ☐ Group H ☐ Shelter ☐ Foster C ☐ Commor ☐ Friend ☐ Unknow	care n Law	

Custody Information	on:					
	Cuctomany Traditi	onal	Orders of Su	nervision		
☐ Customary Traditional		Ullai	☐ Orders of Supervision			
	Adoption		☐ Unsupervised Visitation			
	Biological		☐ Continued Su	•		
	Kinship/Foster		☐ Temporary S	upervision		
	Recent Apprehen	sion	☐ Voluntary Pla	cement Agreement		
	Voluntary Family			Care (Ongoing Fami		
					ily oct vices)	
Social Worker Na	ame and Contact I	nformation:				
	and Social Statu	,	1			
Grade Level	Has an	Has an	Has Received	Has been	Has received a	
	Individual	Academic	Guidance	previously	Behaviour	
	Education Plan	Assessment	Counselling	apprehended	Assessment	
	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
	□ No	□ No	□ No	□ No	□ No	
	☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown	
C Chamical II	an History Cul	ostanoo miayaa	prior to trootme	nt history		
			prior to treatme			
	neir tamily or comn	nunity received tre	eatment for solvent	substance abuse	?	
☐ Yes						
□ No						
☐ Unknown						
If yes, please exp	olain:					
Has your client n	participated in a no	n_residential/com	munity-based subs	tance abuse prog	ram?	
Tras your cherit p	articipateu iri a rio	II-IESIUEIIIIAI/COIIII	nunity-based subs	tance abuse prog	iaiii:	
□ No						
☐ Unknown						
If yes, please exp	olain:					
Has your client r	eceived prior treat	ment at a resident	rial addiction centre	2		
☐ Yes	eceived prior treati	illelli al a l'esidelli	iai addiction centre	7 :		
☐ No						
☐ Unknown						
If yes, please exp	olain:					
• • •						
Treatment Loca	ation	Treatment Date		Describe		
i i i calificiil LUCA	ILIOII	i i calinelil Dale	;	Desci inc		

			(Completed/Not Completed?)
Has your client used substances for	the last year?		
-	•	☐ Yes	
		□ No	
		Unknown	
		□ OHKHOWH	
If yes, complete a DUSI-R Assessme	nt.		
D. Mental Health History			
Provide the following information abo	out the client's me	ental health status	S.
Mental Illness	out the elicites the	Describe	J.
Been diagnosed with a mental illness		Describe	
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 a	bout killing		
themself?			
☐ Yes			
□ No			
□ Unknown			

	T
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:
10.7	
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
γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ	□ No
	☐ Unknown
Is there any history of family violence that the client n	nav have been witness 🔲 Yes
to?	No
	☐ Unknown
Any self-harming behaviour(s)?	☐ Yes
3 • • • • • • • • • • • • • • • • • • •	□ No
	☐ Unknown
Please indicate which (if any) of the following issues	
provide pertinent details in the associated space:	p y 2 2y 3
 Physical aggressive, abusive, or threatening behavior 	, , , , , , , , , , , , , , , , , , , ,
 Verbally aggressive abusive, or threatening behaviors 	s (verbal or physical)
□ Depression	☐ Uncontrollable outburst of anger
☐ Suicidal attempts	☐ Suicidal ideation
	Self-harm or mutilation
	Johniann of Mulialion

Please specify details and dates:				
☐ Running away☐ Severe and debilitating anxiety☐ Eating disorder		Recklessness/unhealthy risk taking Co-dependent/controlling ADHD (Attention Deficit Hyperactivity Disorder)		
Please specify details and dates:				
 □ FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effection □ Intellectual Development Disability □ Dislike of or disregard for the authority figures □ Medical complications that may affect treatment 	cts) 🗆	Mental Disorder Difficulty following rules or regulations Substance withdrawal (detoxification) Other destructive behaviours (i.e., vandalism, arson)		
Does your client go to school? Yes	_	Velfare Involvement? Yes		
□ No		No		
□ Unknown		Unknown		
H. Historical Trauma Event				
Has your client experienced historical trauma?		☐ Yes ☐ No ☐ Unknown		
What kind of historical trauma has your client experie	nced?			
☐ Attended residential school				
☐ Experienced trauma in residential school				
$\ \square$ Experienced physical abuse (not residential so	☐ Experienced physical abuse (not residential school)			
☐ Experienced emotional abuse (not residential school)				
☐ Experienced sexual abuse (not residential school)				
☐ Experienced multiple foster care placements	☐ Experienced multiple foster care placements			
 Experienced trauma in foster care 	☐ Experienced trauma in foster care			
$\ \square$ Was separated from parents/family for other re	☐ 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 pa	ast 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: