



**APPLICATION FOR ADMISSION**

Check One:  Phase I  Family program  Calgary Drug Treatment Court

PERSONAL INFORMATION Admission completed by \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street number City Province Postal Code

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ Alternate # ( ) \_\_\_\_\_

Age \_\_\_\_\_ Date of birth (m/d/yr) \_\_\_\_\_ Health Care Number & Province \_\_\_\_\_

SIN \_\_\_\_\_ Treaty Medical Services:

Treaty Services Card # \_\_\_\_\_ Band Name & Number \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Partnership status:  Single  Common-Law  Married  Divorced  Widowed  Separated  
# of children \_\_\_\_\_ if applicable Ages: \_\_\_\_\_ # of children living with client \_\_\_\_\_ Other dependants: \_\_\_\_\_

Highest level of education:  
 Gr.1-9  Gr.10-12  Some Post-Secondary  University Degree  College Diploma/Degree  Other \_\_\_\_\_

Are you currently employed? \_\_\_\_\_ What is your usual occupation? \_\_\_\_\_ Net monthly Income \_\_\_\_\_

If not employed what is your current means of financial support? \_\_\_\_\_

Source of Income:  Alberta Works  E.I.  Pension  Self-Employed  Company Benefits  
 AISH  Employed  Aboriginal Funding  Trustee  Federal Tax Benefit

Child Maintenance  other specify: \_\_\_\_\_

Income grids: Current Monthly Income \$ \_\_\_\_\_  
 Less than 15,000  Less than \$30,000  Less than \$60,000  over \$70,000

If you receive Alberta Works Assistance, please give the name and # of your Financial Benefits Worker \_\_\_\_\_

**Ethnicity**  
Do you define yourself as: (choose all that apply)  
 Caucasian  Aboriginal Non Status  Aboriginal Treaty Status  Inuit Status  Metis  Indian  Asian  
 African/Black  Middle Eastern  Latin American  Other \_\_\_\_\_

**Next of Kin or Emergency contact (To be notified in case of emergency)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
Street Number City Province Postal Code

Phone ( ) \_\_\_\_\_ Secondary Phone ( ) \_\_\_\_\_

During my treatment at Alcove, I \_\_\_\_\_ give Alcove permission to contact the above next of kin and or emergency contact in case of emergency.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date Signed

<b>OFFICE USE ONLY</b>	
Today's Date _____	Admission Date _____
Type of Treatment	Method of Payment
Drug & Alcohol	Self Child Welfare
Gambling	Social Services AISH
Other (sex, shopping)	Other _____
Program	Application was completed by:
Residential	Referring Party Phone
Out-patient	Self



**PERSONAL INFORMATION CONTINUED**

**Agency Referral Information**

**How did you hear about Alcove?**

AHS office  
Mental Health Worker  
Child Welfare Worker

Physician/Psychiatrist/  
Court/Parole/Probation  
AHS funded agency

**Were you referred by any of the following?**  
Employer/Employee Assistance      Social Services/Income  
Security Worker  
Officer/Lawyer      Other \_\_\_\_\_

Name of referring person \_\_\_\_\_ Agency \_\_\_\_\_

Phone (    ) \_\_\_\_\_ Fax (    ) \_\_\_\_\_

**CURRENT STATUS**

1. When did you last use drugs or consume alcohol? : \_\_\_\_\_
2. What did you use? :     Prescription Drugs       Street Drugs       Alcohol
3. What drugs have you abused? \_\_\_\_\_
4. Is Gambling now or has gambling ever been a problem?       YES       NO
5. When did you last gamble? : \_\_\_\_\_
6. When would you say is your addiction of choice? : \_\_\_\_\_

**ADDICTION HISTORY**

What made you decide to seek help for your addiction at this particular time?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Circle the number that best describes your situation today.**

1. I am not worried about my use of alcohol or drugs or my gambling, and I am here only because someone else requested I come.
2. I am not sure if I have a problem with alcohol, drugs, or gambling.
3. I know I have a problem with alcohol, drugs, or gambling, but I am not sure how to deal with it or how to make changes
4. I am ready to make changes, and I am here to get help to make those changes.
5. I have already made the changes I need to make and I want help to maintain those changes.

**Alcohol and Drug Addiction History**

Please list any substances abuse (past and present), including drugs, alcohol, solvents, prescriptions, over the counter medications, etc.

TYPE OF SUBSTANCE	AMOUNT USED	PATTERN OF USE (daily, weekly, etc.)	TYPE OF USE (intravenous, etc)	LAST USE DATE mm/dd/yy	LENGTH OF USE # of Months/Years?
Alcohol					
Marijuana					
Cocaine					
Heroin					
Prescription					
Meth					
Opiates					
Other					

Have you ever used intravenous drugs?  Yes  No if yes, what did you use, and when did you use it? \_\_\_\_\_

How long have you been abusing alcohol and/or drugs? \_\_\_\_\_

How long have you been able to abstain from using alcohol and/or drugs? \_\_\_\_\_

Please list all withdrawal symptoms you have experienced in the past year. \_\_\_\_\_

### Gambling Addiction History

Please list the types of gambling (past and present) you have participated in. Please include: bingo, VLT's, slots, Internet, casinos, scratch tickets, cards, and lotteries.

TYPE OF GAMBLING	AMOUNT OF MONEY SPENT	PATTERN OF USE (daily, weekly, etc.)	LAST USE DATE

How long have you been gambling? \_\_\_\_\_

Have you spent more money than you intended on any of the above activities?  Yes  No

Has anyone ever expressed concern about your involvement in these activities?  Yes  No

Please list any gambling withdrawal symptoms you have experienced \_\_\_\_\_

How long have you been able to abstain from gambling? \_\_\_\_\_

### Other Addiction History

Do you identify patterns in other areas of your life that may have some addictive qualities? Check (✓) which one(s):

- Internet     
  Relationships     
  Shopping     
  Sex  
 Food     
  Money     
  Other \_\_\_\_\_

Have you ever tried to abstain from any of the above activities?  Yes  No

What is the longest you have ever been able to abstain? \_\_\_\_\_

Have you experienced any withdrawal symptoms?  Yes  No If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Smoking Addiction History**

Do you currently smoke cigarettes?  Yes  No Are you interested in quitting?  Yes  No  
Please describe your pattern of use \_\_\_\_\_

How has your addiction affected the following areas of your life?  
Family: \_\_\_\_\_

Emotional \_\_\_\_\_

Social \_\_\_\_\_

Physical (including the withdrawal symptoms you experience) \_\_\_\_\_

Work/School \_\_\_\_\_

Spiritual \_\_\_\_\_

**PRIOR COUNSELING / TREATMENT HISTORY**

1. Have you ever received counseling for your addiction problem?  YES  NO

2. Have you ever attended any substance abuse programs?  YES  NO

DATE	NAME OF PROGRAM	WHERE	COMPLETED?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

3. Have you attended any self help groups e.g. AA/NA/CA /SAA, Other \_\_\_\_\_  YES  NO?

Check (✓) which one(s):  AA  NA  CA  SAA Other: \_\_\_\_\_

**PREVIOUS TREATMENT**

Have you previously been assessed or received treatment at Alcove?  Yes  No

Date (s) \_\_\_\_\_

Did you complete the program?  Yes  No

Why or why not? \_\_\_\_\_

Please list other addiction treatment or detox programs

AGENCY	REASON FOR TREATMENT	DATES	COMPLETION	
			YES	NO

**Parenting/Family Status**

Are you currently pregnant?  Yes  No If yes, please specify due date/or number of months pregnant \_\_\_\_\_

Have you received pre-natal care?  Yes  No

Please list all children (If applicable)

NAME (First & Last)	AGE	SEX	AT HOME	PLACED WHERE	*CHILD WELFARE STATUS? (e.g. TGO, PGO, CA, SA, SO)
			YES	NO	

\*STATUS KEY    TGO = Temporary Guardianship Order    PGO= Permanent Guardianship Order    CA= Custody Agreement    SA= Support Agreement    SO= Supervision Order

**Children's Services Involvement**

Is addiction treatment a requirement as set out by child welfare?    Yes    No

Are you currently working with a Child and Family Services Worker? \_\_\_\_\_

Case Worker's name \_\_\_\_\_ Office location \_\_\_\_\_

**MEDICAL/PSYCHIATRIC HISTORY**

1. Do you have any medical problems?    YES    NO    If YES, please explain:  
\_\_\_\_\_

2. Are you presently on any medication?    YES    NO  
Current G.P. \_\_\_\_\_ Phone # \_\_\_\_\_

3. Are there any medical limitations that could limit your participation in the program activities or chores?  
YES    NO    If YES, please explain:  
\_\_\_\_\_

4. Do you require any special dietary considerations?    YES    NO    If yes, please explain:  
\_\_\_\_\_

5. Do you have any allergies     YES     NO    If yes, please explain:  
\_\_\_\_\_

6. Do you have any eating disorders?    YES    NO    If yes, please explain:  
\_\_\_\_\_

7. Have you ever been under psychiatric care?    YES    NO  
Reason: \_\_\_\_\_

When? \_\_\_\_\_ Where? \_\_\_\_\_

Have you had any suicidal thoughts or attempts in the past year?  
Please indicate dates and circumstances:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone # \_\_\_\_\_

Mental Health Worker: \_\_\_\_\_ Phone# \_\_\_\_\_

Other Professional Contacts: \_\_\_\_\_ Phone# \_\_\_\_\_

I hereby declare that, to the best of my knowledge, the information contained herein is true and that upon my admission; I agree to abide by any and all rules of Alcove and to notify the staff of any changes in the information contained herein. I also give consent to Alcove to use this information to interact with other agencies as required for purposes of admission and ongoing residency. I also understand that knowingly submitting false information on this application is grounds for voiding this application or dismissal from Alcove.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Other Relevant Information:**

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**MEDICAL AND HEALTH HISTORY**

Please place a check mark indicating whether you have any of the following health problems or diseases (now or in the past).

Seizures	Diabetes	Heart problems	Stroke	Allergies
Eating Disorder	HIV/AIDS	Hepatitis	Blood disorders	Cancer
Respiratory Problem	Fibromyalgia	Vision problems	Hormone problems	Ulcers
Liver problems	Tuberculosis	Arthritis	Osteoporosis	Lupus
Skin problems	Thyroid problems	Chest Pains	Dizziness	
Other _____				

Please list physical conditions (e.g. migraines, dental, chronic back pain, withdrawal symptoms) that may impact participation in treatment or require medical follow-up during treatment and for how long.

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Please describe any accidents or injuries you have had, indicating the year of the accident.

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Have you recently had any health symptoms that you are concerned about or would like some information about? Please describe.

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Please describe any other health problems you have had that are not listed above.

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Please describe any accidents or injuries you have had, indicating the year of the accident.

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Are there any of the following disordered eating behaviours currently present? (within last 6 mos.)

How Often	Last Time	How Managing
<input type="checkbox"/>	Binge Eating	<input type="checkbox"/>
<input type="checkbox"/>	Eating Restrictions	<input type="checkbox"/>
<input type="checkbox"/>	Vomiting/Purging	<input type="checkbox"/>
		<input type="checkbox"/>
		Laxative/Enema Abuse
		Diuretic Abuse
		Excessive Exercising

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Office Location \_\_\_\_\_

Have you ever engaged in high risk sexual activity?  
Have you ever been involved in the sex trade?

**Please list all medications you are currently taking, including over the counter drugs, natural products and vitamins.**

MEDICATION	DOSAGE	REASON FOR USE	START DATE	END DATE

Please list the date of your most recent physical exam \_\_\_\_\_

Do you require a medical exam at this time?   Yes   No

**MENTAL HEALTH INFORMATION**

Are you currently involved with a mental health professional?   Yes   No

Name \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

If yes, please specify: (i.e. Psychiatrist, psychologist, and therapist)

\_\_\_\_\_

Please place a check mark indicating whether you have ever been diagnosed with any of the following mental illnesses.

- Depression                      Anxiety (panic disorder, agoraphobia)   Bi-polar                       (Manic Depression)  
Personality Disorder           Borderline Personality                      Obsessive-Compulsive Disorder  
Attachment Disorder           Post Traumatic Stress Disorder   Attention Deficit Disorder            Other \_\_\_\_\_  
Cognitive impairment (dementia, brain injury)

Do you agree with the diagnosis?    Yes   No   why or why not? \_\_\_\_\_

\_\_\_\_\_

Please place a check mark indicating any of the following concerns.

- Poor memory                      Concentration problems                      Confusion                      Hallucinations Delusions                      Anxiety  
Forgetfulness                      Poor attention span                      Hyperactivity                      Mood swings Fears or Phobias

Have you ever been hospitalized for a mental health reason?   Yes   No

Please indicate the dates and reason for hospitalization.

\_\_\_\_\_

Have you had any of the following Health Risk behaviours currently or within the last 6 months?

- |   |           |           |
|---|-----------|-----------|
|   | How often | last time |
| How Managing                            |           |           |
| Seizures                                |           |           |
| Suicidal thoughts or attempts?          |           |           |
| Self Inflicted Violence                 |           |           |
| Hospitalization for Psychiatric illness |           |           |

Please indicate the dates and circumstances.

\_\_\_\_\_

Are you currently having any mental health symptoms that you would like help with? Please describe.

\_\_\_\_\_

\_\_\_\_\_

Please list the date of your most recent physical exam \_\_\_\_\_

**COURT / LEGAL INFORMATION**

1. Do you have a criminal record? If **YES use back of page** to list offences YES NO

2. Do you have **any** pending traffic, civil or criminal cases? YES NO

**Charges:** \_\_\_\_\_

**Court:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Where:** \_\_\_\_\_

LEGAL HISTORY: Please select all that apply. If yes to any of these, please describe:

- Do you have a history of Violence?
- Possession, Trafficking of Narcotics?
- Current legal involvement?

**Are you currently: on Parole on Probation Incarcerated or under House Arrest?**

**Are you on: Day Parole Temporary Absence Conditional Sentence**

**Probation/Parole Officer/ Case Worker** \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Do you have any outstanding legal charges? Yes No  A copy of document provided  
If yes, please describe

Upcoming court date(s) \_\_\_\_\_

**FAMILY AND SOCIAL HISTORY-** (if you require additional space please use the back of this form)

**Family History**

Is there an addiction history in your family? Yes No If yes, please specify who and what

Briefly describe your relationship with your parents/caregivers while growing up and at the present

**SOCIAL HISTORY**

Have you experienced any of the following types of abuse?

Physical, Emotional, Sexual, Financial, Other \_\_\_\_\_

Is this the first time you've talked about this?

Please describe significant life losses.

Death/loss of a child \_\_\_\_\_

Loss of job \_\_\_\_\_

Divorce/Separation \_\_\_\_\_

Death of a family member \_\_\_\_\_

Health problems \_\_\_\_\_

Other \_\_\_\_\_

Please list all supports you have (i.e.12/16 Step, Family, Friends, Church, Community Agencies etc.)



**CONSENT FOR RELEASE AND COLLECTION OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ give permission to Alcove to contact:

<b>TO/FROM</b>	<p>Organization: Justice, Alberta Health Services, Calgary Health Region and all its divisions, including but not limited to:</p> <ul style="list-style-type: none"> <li>Emergency Medical Services</li> <li>Rockyview Hospital</li> <li>Sheldon M Chumir Health Centre – Urgent Care</li> <li>Foothills Hospital</li> <li>Peter Lougheed Hospital</li> <li>Mobile Response Team</li> <li>Calgary Housing Company</li> <li>New Beginnings</li> <li>Peer Support Services for Abused Women</li> <li>Calgary Drug Treatment Court</li> </ul>
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<b>WHAT INFORMATION</b>	<p><b>To release verbally or in writing:</b></p> <p>Please check the following information to be released</p> <p> <input type="checkbox"/> Assessment                      <input type="checkbox"/> Participation  <input type="checkbox"/> Attendance                      <input type="checkbox"/> Program Dates  <input type="checkbox"/> Summary &amp;                      <input type="checkbox"/> Progress Summary  Recommended Actions              <input type="checkbox"/> Treatment Plan  <input type="checkbox"/> Other (Please Specify)  Any and all relevant medical information </p>	<p><b>To collect verbally or in writing:</b></p> <p>Please check the following information to be collected</p> <p> <input type="checkbox"/> Assessment                      <input type="checkbox"/> Progress Summary  <input type="checkbox"/> Attendance                      <input type="checkbox"/> Reason for Referral  <input type="checkbox"/> Relevant History                      <input type="checkbox"/> Service Monitoring  <input type="checkbox"/> Participation                      <input type="checkbox"/> Treatment Summary  <input type="checkbox"/> Other (Please Specify)  <u>Any and all relevant medical information</u> </p>
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<b>TO/FROM</b>	<p>Organization: Justice but not limited to:</p> <p>Calgary Drug Treatment Court</p>
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<b>CONSENT</b>	<p>I understand that provision of treatment services is not dependent upon my decision to release information and that I may cancel this consent at any time. I also understand that some action may have been taken prior to cancellation.</p> <p><b>Client Signature:</b> _____</p> <p><b>Witness:</b> _____</p> <p><b>Date signed:</b> ____ / ____ / ____      <b>Permission will expire on:</b> ____ / ____ / ____</p> <p align="center">Year                      Month                      Day                      Year                      Month                      Day</p>
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<b>CANCEL</b>	<p>I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation.</p> <p><b>Client Signature:</b> _____      <b>Witness:</b> _____</p>
	<p><b>Date signed:</b> ____ / ____ / ____</p> <p align="center">Year                      Month                      Day</p>



**ALCOVE  
HEALTH / MEDICAL INFORMATION RELEASE  
CONSENT FORM**

I, \_\_\_\_\_, (Resident) authorize the release of the following health information contained in:  
Diagnostic, treatment and care information  
Registration information  
Health services provider information  
Incident reports, shift reports  
Other (specify)

And not limited to any personal or health information, records or knowledge about me can be given to the Program Coordinator, or to their designate acting for me, for the purpose of my personal file at Alcove. This information may be obtained from, but not limited to, any person, organization or institution, including any of the following; physicians or other health care practitioners or providers, hospitals, clinics or other medically related facilities, clergy, legal, justice and investigation agencies.

I understand that this authorization is required in order to assess my suitability for Alcove program and further agree if I am a successful applicant, may be required for review during my time in the program, in order to ensure that I continue to meet the requirements of the program and to identify my areas of need while in the program.

I acknowledge that I have been made aware of why my health information or the health information of the individual I am authorized to sign for is required, and the risks and benefits to myself, or the individual I am authorized to sign on behalf of.

I agree that a copy of this signed authorization for Alcove to obtain information is as valid as the original.

I understand that I may revoke this consent at any time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient/Resident/Client  
Guardian  
Agent  
Personal Representative

Witness Signature \_\_\_\_\_

Date: \_\_\_\_\_

I, \_\_\_\_\_, understand that my treatment and any information I may share at Alcove is confidential and that any release of information shall require a signed release from me.

I further understand the following limits of confidentiality. Alcove staff may release pertinent information to the appropriate authorities including, but not limited to, police officers, medical personnel, the Child and Family Service Authority, without a signed release in the following circumstances:

- a. The information involves a threat of harm to self or others.
- b. The information involves concerns about the abuse or neglect of a child.
- c. When Alcove is legally obligated to do so (e.g. a client's file or staff member is subpoenaed by the judicial system).

I understand that treatment information is recorded in my client file for reference and that Alcove staff share information to assist them in delivering the most effective treatment.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## MEDICAL ASSESSMENT FORM

This form must be completed by a physician. The cost of the health questionnaire is the responsibility of the client. This information is being collected under the authority of the Alberta Alcohol and Drug Abuse Act.

Date: \_\_\_\_\_ **Patient Name:** \_\_\_\_\_

DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

**Medical History** \_\_\_\_\_

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

**Psych History** \_\_\_\_\_

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

**Surgical History** \_\_\_\_\_

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

Medications \_\_\_\_\_

Allergies (*please specify*) \_\_\_\_\_ Anakit \_\_\_\_\_

Dietary Requirements \_\_\_\_\_

### DRUG HISTORY

	Name of Drug	Date of last use
Alcohol	_____	_____
Cannabis	_____	_____
Cocaine	_____	_____
Opiates	_____	_____
Amphetamines (Including crystal meth)	_____	_____
Benzodiazepines	_____	_____
Other	_____	_____

### PHYSICAL EXAM

**HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_ **BP** \_\_\_\_\_ **PULSE** \_\_\_\_\_

**ENT** \_\_\_\_\_ **CHEST** \_\_\_\_\_

**CVS** \_\_\_\_\_ **ABD** \_\_\_\_\_

**NEURO** \_\_\_\_\_ **M/SK** \_\_\_\_\_

**SKIN** \_\_\_\_\_ **ENDO** \_\_\_\_\_

HISTORY	YES	NO	Comments explain YES responses
Drug & Alcohol Abuse or addiction			
Mental Health Disorders			
Eating Disorder			
Sleep Disorder			
Nervous Disorders			
Urinary tract disorders			
Hepatic Disorders (Hepatitis, HBV, HCV)			
Circulatory system Disorder			
Reproductive System Disorder			
Respiratory System Disorder			
Gastrointestinal Disorder			
Pancreatic Disorder (diabetes)			
Pain- Chronic, Acute			
Suicidal tendencies			
Attempted Suicide			
Seizures			
STD's including HIV, AIDS			
Liver Function Test			
Other health related problems			
Blood Pressure _____ / _____			
Blood Sugar _____			
Weight Loss _____ lbs time span _____			
Calcium Level:			
Zinc Level:			
Magnesium Level:			
B12 Level:			
Vitamin D Level:			
Fatigue			
Night Sweats			
Fever			
Blood in Sputum			
Cough lasting longer than 2 weeks			
Exposure to Tuberculosis			
Chest X-Ray results			
Birth or travel to place with high incidence of Tuberculosis			
Previous treatment for Tuberculosis			
Poor general health status			
Chronic medical conditions			
Possible risk factor for progression of disease			
Further screening required			
Further assessment required			
Other risk factors for infection			
Pregnancy if yes # of months			
Disabilities			
Eyesight problems			
Dental problems			

**Client is medically and physically able to participate in an intensive group-counseling program.**

Physician Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for completing the attached form. Please fax to: 403-242-3915