Alcove
Addiction Recovery for Women

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 **Witness**

_____ _____
Date Signed **Date Signed**

OFFICE USE ONLY

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

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PERSONAL INFORMATION CONTINUED

Agency Referral Information

How did you hear about Alcove?

Were you referred by any of the following?

AHS office | Physician/Psychiatrist/ | Employer/Employee Assistance | Social Services/Income
Mental Health Worker | Court/Parole/Probation | Security Worker
Child Welfare Worker | AHS funded agency | 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?
			☐YES ☐NO
			☐YES ☐NO
			☐YES ☐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:

_____

_____

_____

_____

_____

_____

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.

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

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

_____

_____

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

_____

_____

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

_____

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

How Often	Last Time	How Managing
☐ Binge Eating		☐ Laxative/Enema Abuse
☐ Eating Restrictions		☐ Diuretic Abuse
☐ Vomiting/Purging		☐ 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_____

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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.)

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CONSENT FOR RELEASE AND COLLECTION OF CONFIDENTIAL INFORMATION

I, _____ give permission to Alcove to contact:

TO/FROM	Organization: Justice, Alberta Health Services, Calgary Health Region and all its divisions, including but not limited to: Emergency Medical Services Rockyview Hospital Sheldon M Chumir Health Centre – Urgent Care Foothills Hospital Peter Lougheed Hospital Mobile Response Team Calgary Housing Company New Beginnings Peer Support Services for Abused Women Calgary Drug Treatment Court

WHAT INFORMATION	**To release verbally or in writing:** Please check the following information to be released ☐ Assessment ☐ Participation ☐ Attendance ☐ Program Dates ☐ Summary & ☐ Progress Summary Recommended Actions ☐ Treatment Plan ☐ Other (Please Specify) Any and all relevant medical information	**To collect verbally or in writing:** Please check the following information to be collected ☐ Assessment ☐ Progress Summary ☐ Attendance ☐ Reason for Referral ☐ Relevant History ☐ Service Monitoring ☐ Participation ☐ Treatment Summary ☐ Other (Please Specify) Any and all relevant medical information

TO/FROM	Organization: Justice but not limited to: Calgary Drug Treatment Court

CONSENT	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. **Client Signature:** _____ **Witness:** _____ **Date signed:** _____ / _____ / _____ **Permission will expire on:** _____ / _____ / _____ **Year Month Day Year Month Day**

CANCEL	I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation. **Client Signature:** _____ **Witness:**_____
	Date signed: _____ / _____ / _____ **Year Month Day**

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

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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-counselling program.

Physician Name: _____ Physician Signature: _____Date: _____

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