Client Admission Form

This is an interactive document. Simply place your cursor over the item you wish to fill in and begin typing.
Please complete and submit online (see the SEND button on page 4). Alternatively you can print this document and fax to 1-604-487-9012. A staff member will contact you within 24 hours.

Client (Patient) Information:

Name
(First) (Middle Initial) (Last)

Address
Street/PO Box

City/Town

Prov/State Postal/Zip

Tel Home: Cell:

Other (specify):

Email address:

Age Date of Birth

Provincial Health Care No.

Requested Admission Date:

Extended Health Benefit No.

Funding Guarantor (if different from client):

Name
(First) (Last)

Address
Street/PO Box

City/Town

Prov/State Postal/Zip

Telephone Numbers
Home: Work:

Relationship to client? self-pay EAP employer family member other

Payment

How will you be paying? cheque money order wire transfer credit card

I acknowledge that I have read the Agreement of Responsibility for Residential Treatment Costs and agree to it's terms.

Source of Information (if different from Client or Guarantor):

Name of person completing this application:

(First) (Last)

Relationship to Client

Telephone Numbers
Home: Work:

Cell:

Referring Professional:

Were you referred to Sunshine Coast Health Center by one of the following professionals?

Therapist/Counsellor	Yes	No
Psychologist	Yes	No
Physician	Yes	No
Psychiatrist	Yes	No
Interventionist	Yes	No
Other	Yes	No

If yes, name of professional(s):

1. Precipitating Event/Motivation

Has a specific event(s) prompted this application?
Yes No

If yes, please describe.

Continued on next page

2. Medical History (Biomedical Complications)

Primary Physician

City/Town

Prov/State

Office Telephone Number

Have you had any medical conditions/illnesses within the past two years? Yes No

If yes, please identify.

Are you taking any prescribed medications?
Yes No

Are you taking any over-the-counter drugs?
Yes No

If yes to either question, please provide name, dosage, duration of use, and reason taken.

Have you been hospitalized in the past year?
Yes No

Have you ever attempted suicide?
Yes No

If yes to either question, please describe and provide date(s).

Please identify any known allergies.

Do you snore or have problems sleeping?
Yes No

Are you able to walk, feed, dress and care for yourself independently? Yes No

3. Psychological History (Emotional/Behavioral)

Are you **currently** seeing a psychiatrist?
Yes No

Name of psychiatrist?

Are you **currently** seeing:

Pyschologist? Yes No

Counsellor? Yes No

Name of Professional:

City/Town Prov/State

Office Telephone Number

Have you had any psychological/emotional problems in the **past two years?** Yes No

If yes, please identify.

Continued on next page

4. Alcohol/Drug History

Complete for alcohol or any other addictive substances you have used (including nicotine) in the **past 6 months**.

Name of Drug
Pattern of use (daily, weekend, binge)
Amount used per occasion
Length of use
Date of last use

Name of Drug
Pattern of use
Amount used per occasion
Length of use
Date of last use

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Pattern of use
Amount used per occasion
Length of use
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Name of Drug
Pattern of use
Amount used per occasion
Length of use
Date of last use

5. Treatment History

Have you previously been to treatment?
Yes No

If "Yes," please detail the history. If you require more space, please insert extra page(s).

Name of Program
Where located
When
Inpatient or residential?
Was Program Twelve-Step based? Yes No
Did you complete the program? Yes No
If "No," how come?

Outcome (length of abstinence)

Name of Program
Where located
When
Inpatient or residential?
Was Program Twelve-Step based? Yes No
Did you complete the program? Yes No
If "No," how come?

Outcome (length of abstinence)

Name of Program
Where located
When
Inpatient or residential?
Was Program Twelve-Step based? Yes No
Did you complete the program? Yes No
If "No," how come?

Outcome (length of abstinence)

Continued on next page

6. Family

Current marital status? Single Married
Divorced Separated Widowed

Ages of children?

Is there a family history of alcohol/drug use or dependence? Yes No

If yes, please describe.

7. Employment Status

Current employment status?
Employed Unemployed

Length of current status

If employed, please describe nature of job.

Please describe impact of alcohol/drug use on employment history.

8. Legal History

Have you ever been charged or convicted with a Criminal Code offence(*)?
Yes No

(*)Note: for American applicants, Criminal Code offences refer to misdemeanor or felony convictions.

If yes, please describe (include DUIs).

If yes, do you have any pending hearings?
Yes No

9. Nutrition

Do you have any special dietary concerns?
Yes No

If yes, please describe.

10. Recovery

Please identify any strengths or resources for recovery, e.g., family support, employer support, personally motivated, etc.

Please identify any current obstacles to treatment or recovery.

Thank you. If you have any questions regarding this application or prefer to complete the questionnaire over the phone, please contact us toll-free at 1-866-487-9010.

For Office Use Only
☐ RP ☐ I ☐ GAW ☐ Y ☐ WM ☐ A ☐ O

Click here to submit this form online.