Sunshine Coast Health Centre
A Non 12-Step Program

# 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, PRINT THIS DOCUMENT AND FAX TO 1-888-875-0511. 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

Telephone Numbers
Home: Cell:

Other (specify):

Email address:

Age Date of Birth

Provincial Health Care No.

Extended Health Care No.

Extended Health Carrier

Group Plan No. (Back of Card)

Requested Admission Date:

## 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

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

Name of person completing this application:
(First) (Last)

Relationship to Client

Telephone Numbers
Home: Work:

Cell:

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## Referring Professional (if applicable):

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

- ☐ Therapist
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Interventionist
- ☐ Other: _____

Name of Professional(s):

## 1. Precipitating Event/Motivation: Has a specific event(s) prompted this application?

◯ Yes ◯ No

If yes, please describe:

What else is motivating your desire for treatment?

Lack of social support/feelings of loneliness and isolation
◯ No ◯ Yes

Relationship problems with partner or family members
◯ No ◯ Yes

Money problems/dissatisfaction with work ◯ No ◯ Yes

Physical health problems ◯ No ◯ Yes

Mental health problems ◯ No ◯ Yes

Problems with living arrangement or housing ◯ No ◯ Yes

If yes to any, please describe:

What do you think you need to work on the most during your treatment at SCHC? Please describe:

On a scale of 1 to 10,
(1 being very low and 10 being very high) rate the extent to which you are currently experiencing :

- Hope
- Fear
- Anxiety
- Relief
- Shame
- Hopelessness
- Dread
- Frustration
- Optimism
- Anger
- Resentment

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## 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

Are you currently taking any nutritional supplements or herbal medicines? ◯ No ◯ Yes

If yes, name of nutritional supplement or herbal medicine

Amount per use:

Length of time on this nutritional supplement or herbal medicine:

Please note that any nutritional supplement or herbal medicine brought to treatment is subject to confiscation and disposal. Any exceptions must be pre-approved by medical staff.

Have you ever attempted suicide?
◯ Yes ◯ No

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

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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:

Psychologist? ◯ Yes ◯ No

Counsellor? ◯ Yes ◯ No

Name of Professional(s):

City/Town Prov/State

Office Telephone Number

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

If yes, please describe:

## 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

**Name of Drug**

Pattern of use

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

## 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).

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### Name of Program

Where located

When

Outpatient or residential?

Was Program Twelve-Step based? ◯ Yes ◯ No

Did you complete the program? ◯ Yes ◯ No

If "No," how come?

Outcome (length of abstinence)

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Outcome (length of abstinence)

## 6. Family

Current marital status? ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Common Law

Ages of children (if any)?

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

If yes, please describe:

### Family Services

Do you have any family members interested in participating in the Family Services? ◯ Yes ◯ No

If so, please detail:

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## 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

If yes, when?

## 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:

What are your top three goals (objectives) for coming to SCHC?

What is your understanding of your addiction? Why do you think you engaged in your addiction?

What is your understanding of your current struggles and challenges in life?

**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

**SUBMIT**