Manie Daniels Center

261 Maberly-Elphin Road
Maberly, On
K0H 2B0

Preliminary Intake Assessment Form

Applicant Information

Personal Information	
Full Name:	
Phone:	Date of Birth:
Email:	
Address:	
City, Province:	Postal Code:

Referring Institution:	
Institution:	
Referred by (names):	
Phone:	Email:
Address:	
City / Province:	

Emergency Contact	
Name:	Relationship:
Phone:	Email:
Address:	

Lawyer Contact	
Attorney Name/Office:	
Phone:	Email:

Education / Work Experience	
☐ Some high school	☐ High school or GED
☐ Trade School	☐ Some college/university
☐ College/University Degree	☐ Previous/Current Business owner
☐ Trade School	☐ Other
What work experience do you have?	

Source of Funding for Treatment Fees	
☐ Social Assistance (Welfare)	☐ Correctional Service of Canada (CSC)
☐ Employment Insurance (EI)	☐ Canada Pension Plan (CPP)
☐ Ontario Works (OW)	☐ Self-Paying
☐ Ontario Disability Support Program	☐ Other

LEGAL INFORMATION

Are you pre-sentenced? *(waiting on trial/plea)* ☐ Yes ☐ No
Did you have a bail hearing? ☐ Yes ☐ No *If yes, provide date and details:* *If bail was declined, provide reason:*
Do you have any outstanding warrants/charges? ☐ Yes ☐ No *If yes, provide details:* Do you have any charges in any other court/city/province? ☐ Yes ☐ No *If yes, provide details:*

Do you have a criminal record? ☐ Yes ☐ No *If yes, please list your convictions:* Do you have a history of sexual offences? ☐ Yes ☐ No Do you have a history of arson? ☐ Yes ☐ No

Current / Pending Criminal Charges	
Do you have pending civil, traffic or criminal cases?	
Please list your charges:	
Court Location:	Court Date(s):

Legal Status
Is treatment court-mandated? ☐ Yes ☐ No
Are you presently on parole? ☐ Yes ☐ No
If yes to any of the above, please list your conditions:

SUBSTANCE USE & TREATMENT HISTORY

Last Substance Use					
What was the last date you used any drug(s) or alcohol?					
What did you use?					
Substance Use History					
Substance	Method of Use (e.g. smoke, snort, IV)	Amount	Frequency	Age of First Use	Date Last Used
Alcohol					
Marijuana					
Crack					
Cocaine					
Crystal Meth					
Heroin					
Fentanyl					
Ecstasy					
GHB					
Illicit Methadone					
Inhalants					
Benzodiazepines					
Prescription Drug Abuse					
Tobacco					
Other:					

Opiate Replacement Therapy	
Are you currently on an opiate replacement? ☐ Yes ☐ No	
If yes, what are you taking? ☐ Methadone ☐ Suboxone ☐ Sublocade ☐ Other	
How long have you been on opiate replacement therapy?	
What is your current dose?	
Name of prescribing physician:	Physician's Phone:

Treatment History		
Have you previously received counselling for your addiction? ☐ Yes ☐ No		
Do you currently have an addictions counsellor? ☐ Yes ☐ No		
Name:	Phone:	Agency:
Have you previously attended substance use treatment program(s)? ☐ Yes ☐ No		
Dates	Program	Did you complete?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
Have you ever been asked to leave a program? ☐ Yes ☐ No *If yes, please explain why:*		

FAMILY & RELATIONSHIP BACKGROUND

Family Status			
Do you have any sisters?	☐ Yes	☐ No	*How many?*
Do you have any brothers?	☐ Yes	☐ No	*How many?*
Did you spend time in foster care?	☐ Yes	☐ No	*How much time?*
Are there any signs of alcoholism or substance abuse among your family members? ☐ Yes ☐ No If yes, please provide details:			

Relationship Status
What is your current marital status? ☐ Single ☐ Common-Law ☐ Married ☐ Divorced ☐ Widowed ☐ Other:
How would you assess your current relationship? ☐ Excellent ☐ Good ☐ Complicated ☐ Bad ☐ Other:
Do you have any daughters? ☐ Yes ☐ No *How many?*
Do you have any sons? ☐ Yes ☐ No *How many?*
Who is taking care of your child(ren) right now? ☐ Spouse/Partner ☐ Family Member ☐ Foster Care ☐ Other:

PHYSICAL HEALTH

Medicare Care Provider	
Do you currently have a doctor? ☐ Yes ☐ No	
Name:	Phone:
Agency/Office:	

Medical History		
Do you have a medical diagnosis? ☐ Yes ☐ No *If yes, please list:*		
Are you currently taking any medications? ☐ Yes ☐ No		
Diagnosis	Medication(s)	Dosage
Have you been hospitalized in the last year? ☐ Yes ☐ No *If yes, please explain why:*		
Do you have any allergies? ☐ Yes ☐ No *If yes, please provide details:*		
Do you have any communicable diseases? ☐ TB ☐ HIV ☐ Hep A, B, or C ☐ Other:		

MENTAL HEALTH

Mental Health

Do you have a psychiatric diagnosis? ☐ Yes ☐ No

Check all that apply: ☐ Depression ☐ Anxiety ☐ PTSD ☐ OCD ☐ Other:

Please list other psychiatric diagnosis that apply:

Are you currently taking any medications relating to your psychiatric health? ☐ Yes ☐ No

Diagnosis	Medication(s)	Dosage	How long have you been taking?

Do you have a history of any of the following:

☐ Suicide Attempts ☐ Self-Harming Behaviours ☐ Eating Disorder(s) ☐ Fire-setting Behaviours ☐ Other:

When was the date of your most recent hospital stay? And why?

Do you have any other comments about your mental health?

Have you ever struggled with any of the following:

☐ Sex Addiction ☐ Grief & Loss ☐ Problem Gambling ☐ Other – please explain:

Do you currently have a mental health care worker, mental health team, or psychiatrist? ☐ Yes ☐ No If no, would you like to be connected with a Mental Health Worker? ☐ Yes ☐ No	
Community Mental Health Worker/Team	
Name:	Phone:
Agency/Office:	
Psychiatrist	
Name:	Phone:
Agency/Office:	

SPIRITUAL/RELIGION

Spiritual / Religious Beliefs
Do you have any spiritual/religious beliefs? ☐ Yes ☐ No *If yes, please provide details:*
Do you have any active devotional life or other spiritual practices? ☐ Yes ☐ No
Was your family an influence on your spiritual/religious life? ☐ Yes ☐ No *If yes, please provide details:*
How would you describe your experience with spirituality/religion? ☐ Positive ☐ Negative
Do you see a connection between your spiritual/religious life and substance abuse? ☐ Yes ☐ No *If yes, please provide details:*

PROGRAM READINESS

Are you ready?
Is there anything that would prevent you from participating with community meals and/or household chores? ☐ Yes ☐ No *If yes, please explain:*
Please list any challenges you've faced in the past, relating to your recovery:
What personal assets will aid you in your recovery?
Have you had any experience in working within the 12-step program? ☐ Yes ☐ No *If yes, how long have you worked in the program?*