Alcare Place Recovery Program Application

The Alcare Place Application Package includes the following:

1. Assessment Application
2. Confidentiality and Exceptions to Confidentiality
3. Privacy Notice and Consent Form
4. Alcare Place Guidelines for Residents
5. Admission Criteria for Residents

Name:____
First Middle Last

Date of Birth:______________________ City of Birth:______________________

Address

____
____
____
____

Contact Information

Home Phone:________________ Work Phone:________________ Cell:________________

Voice Mail OK ☐ Voice Mail OK ☐ Voice Mail OK ☐

Email:______________________________

Emergency Contact:______________________ Phone Number:______________________

Relationship:______________________ Address:______________________
____
____

Health Card #:______________________ Family Dr:______________________

Expiry Date:______________________ Doctor Aware of Addiction: Yes ☐ No ☐

Current Medications	Dosage	Details
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Name:______________________________

Are you currently prescribed methadone or any other opioid substitute? Yes ☐ No ☐
If yes, please specify:____
____
____

Have you ever been told that you have a communicable disease? Yes ☐ No ☐
If yes, please specify:____
____
____

Have you ever been diagnosed with a mental health issue?

By Whom?	Diagnosis/Outcome	When

Have you ever been sexually, physically, or emotionally abused? Yes ☐ No ☐
If yes, please specify:____
____
____

Have you ever had an experience with self-harm? Yes ☐ No ☐
If yes, please specify:____
____
____

Have you ever been charged with an offence involving violence? Yes ☐ No ☐
If yes, please specify:____
____
____

Do you have any concerns about gambling (i.e. debts, lottery tickets, etc.)? Yes ☐ No ☐
If yes, please specify:____
____
____

Do you find yourself pre-occupied with sexual thoughts and activities? Yes ☐ No ☐

Do you find yourself pre-occupied with food, thinking about it, eating too much or not enough? Yes ☐ No ☐

Do you have any legal problems?____
____
____

Name:______________________________

Describe any current of past legal convictions?

Do you have any driving infractions?

Are you on probation/parole or any community supervision order? Yes ☐ No ☐
If so, identify restrictions and conditions:

Have people ever told you that you have an anger problem? Yes ☐ No ☐
Comments:

Any other issues to add or discuss that maybe relevant to your treatment?

Please list all known current physical conditions, hospitalizations, physical limitations, etc.:

Name:

Funding

Who will be funding your treatment?______________________________

Insurance (if applicable):

Person insured______________________ Date of Birth:__________________

Group policy #:______________________

Who referred you to Alcare Place? Self ☐ Other ☐ Name (if other):__________________

Did your employer initiate the referral? Yes ☐ No ☐

Your Occupation:______________________________

Is your continued employment dependent upon treatment? Yes ☐ No ☐

Financial Concerns:______________________________

____

____

____

General

Education:______________________________

____

____

Marital Status: Single ☐ Widowed ☐ Separated ☐

Married ☐ Divorced ☐ Common-law ☐

Living arrangement:______________________________

____

____

Are housing arrangements safe and stable for recovery?______________________________

____

____

Children Names	**Age**

Name:______________________

Is there anything that would prevent your full participation in treatment at this time? Yes ☐ No ☐
If yes, please specify:____

In your estimation, do you live with someone who abuses alcohol and/or drugs? Yes ☐ No ☐
If yes, what substances:____

Is there a family history of addiction or mental issues? Yes ☐ No ☐
If yes, please specify:____

What was the event or crisis that resulted in your wanting to come to Alcare Place? Please be specific:________________

Please check off any issues/concerns that you may have to address:

☐ Alcohol	☐ Legal Problems
☐ Drugs	☐ Education
☐ Other Substance Use	☐ Employment
☐ Anger	☐ Sleep
☐ Stress	☐ Suicidal Ideation
☐ Nutrition/Eating Patterns	☐ Suicide Attempts
☐ Relationships	☐ Communication
☐ Medical – Physical Health	☐ Leisure
☐ Isolation	☐ Accommodations
☐ Sexual Identity	☐ Support Network
☐ Sexually Abused	☐ Reading/Writing
☐ Sexually Abusive	☐ Post – Traumatic Stress
☐ Mental Health	☐ Other:

Anything you want to add:____

Name:____________________________

Alcohol and Drug Use

List according to preference:

Substance	Age started	How Long did you use	Times per week
How much last month:		Last use:	

Substance	Age started	How Long did you use	Times per week
How much last month:		Last use:	

Substance	Age started	How Long did you use	Times per week
How much last month:		Last use:	

Substance	Age started	How Long did you use	Times per week
How much last month:		Last use:	

Have you ever had a medical incident as a result of usage? Yes ☐ No ☐

If yes please specify:____

____

____

Have you ever been in counseling/treatment for any addiction or compulsive behavior? Yes ☐ No ☐

Where	Approximate Dates	Length of Involvement	Outcome

Signed:______________________________ Date:______________________________

Witnessed:______________________________ Date:______________________________

Name:______________________________