###### TERRADYNE WELLNESS CENTER CLIENT ADMISSION

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **First Name** | | **Last Name** | | **Previous Last Name (if applicable)** | | |
| **Birth Date (day/month/year)** | | | | **Sex** | | | |
| **Street Address and Apt Number** | | | | | | **Postal Code** |
| **Phone Number** | **Alternate Phone Number** | | | | **Is it OK to leave a message?**  **Yes**  **No** | |
| **Emergency Contact Name** | **Your relationship to this person** | | | | **Emergency Contact Phone Number** | |
| **Family Physician/Nurse Practitioner** | | |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please check the reason you are interested:** | | | Your own substance use | | | Someone else’s substance use |
| **If you are here because of someone else’s substance use, check your relationship with that person:** | | | | | | |
| Partner | Parent | Child | Friend | Employee/ Co worker | Other | |
| **Who recommended that you contact us?** | | | | | | |
| Self  Family  Probation  Doctor  Therapist  School  Employer  Other (specify) | | | | | | |
| **What are your specific expectations/goals for coming to Terradyne Wellness Center?** | | | | | | |
| **Are you currently receiving counselling or support from any other service?** If yes, please list  Yes  No | | | | | | |
| **Do you have any mental health or physical health concerns?** If yes, please list  Yes  No | | | | | | |
| **Are you currently on any mental health medications (i.e. antidepressants, SSRI’s, mood stabilizers, major tranquilizers)?** If yes, please list  Yes  No | | | | | | |
| **Have you ever attempted suicide or seriously harmed yourself?**  If yes, please explain  Yes  No | | | | | | |
| **Are you currently having thoughts of suicide or harming yourself?** If yes, please explain  Yes  No | | | | | | |

**Identify the Substance(s) you are Currently Concerned About**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Substance | **Level of Concern**  **Low Medium High** | | | **Date of last use?** |
| Alcohol |  |  |  |  |
| Marijuana/Hash |  |  |  |  |
| Cocaine/Crack |  |  |  |  |
| Opioids (heroin, morphine, Fentanyl, etc.) |  |  |  |  |
| Benzodiazepines (Valium, Ativan, Xanax etc.) |  |  |  |  |
| Club drugs (ecstasy, Ketamine, GHB etc) |  |  |  |  |
| Hallucinogens (mushrooms, LSD, Salvia, etc) |  |  |  |  |
| Amphetamines (crystal meth, Dexedrine, Ritalin, etc) |  |  |  |  |
| Tobacco/E-cigarettes |  |  |  |  |
| Other Drugs (specify) |  |  |  |  |

Many people that come to our treatment center have had problems with the following concerns. Please answer whether you have had any of these concerns, as this will help us to give you the best support. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was:

In the past month (**4**), 2 or 3 months ago (**3**), 4 to 12 months ago (**2**), 1 or more years ago (**1**), or never (**0**)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **When was the last time that……..** | In the past month | 2 or 3 months ago | 4 to 12 months ago | 1or more years ago | never |
| a. you used alcohol or drugs weekly or more often? | 4 | 3 | 2 | 1 | 0 |
| b. you spent a lot of time either getting alcohol or getting other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g. feeling sick)? | 4 | 3 | 2 | 1 | 0 |
| c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people. | 4 | 3 | 2 | 1 | 0 |
| d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home or social events? | 4 | 3 | 2 | 1 | 0 |
| e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or drugs to stop from being sick or avoid withdrawal problems? | 4 | 3 | 2 | 1 | 0 |
| **2. When was the last time that you had significant problems with…..** |  |  |  |  |  |
| a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? | 4 | 3 | 2 | 1 | 0 |
| b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? | 4 | 3 | 2 | 1 | 0 |
| c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen. | 4 | 3 | 2 | 1 | 0 |
| d. becoming very distressed and upset when something reminded you of the past? | 4 | 3 | 2 | 1 | 0 |
| e. thinking about ending your life or committing suicide? | 4 | 3 | 2 | 1 | 0 |
| f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts? | 4 | 3 | 2 | 1 | 0 |
| **3. When was the last time that you did the following things *two* or more times?** |  |  |  |  |  |
| a. lied or conned to get things you wanted or to avoid having to do something | 4 | 3 | 2 | 1 | 0 |
| b. had a hard time paying attention at school, work, or home | 4 | 3 | 2 | 1 | 0 |
| c. had a hard time listening to instructions at school, work, or home | 4 | 3 | 2 | 1 | 0 |
| d. had a hard time waiting for your turn | 4 | 3 | 2 | 1 | 0 |
| e. were a bully or threatened other people | 4 | 3 | 2 | 1 | 0 |
| f. started physical fights with other people | 4 | 3 | 2 | 1 | 0 |
| g. tried to win back your gambling losses by going back another day | 4 | 3 | 2 | 1 | 0 |
| **4. When was the last time that you….** |  |  |  |  |  |
| a. had a disagreement in which you pushed, grabbed, or shoved someone? | 4 | 3 | 2 | 1 | 0 |
| b. took something from a store without paying for it? | 4 | 3 | 2 | 1 | 0 |
| c. sold, distributed, or helped to make illegal drugs? | 4 | 3 | 2 | 1 | 0 |
| d. drove a vehicle while under the influence of alcohol or illegal drugs? | 4 | 3 | 2 | 1 | 0 |
| e. purposely damaged or destroyed property that did not belong to you? | 4 | 3 | 2 | 1 | 0 |
| **5. When was the last time that you had significant problems with.. (not related to alcohol or drug use)** |  |  |  |  |  |
| a. missing meals or throwing up much of what you did eat to control your weight? | 4 | 3 | 2 | 1 | 0 |
| b. eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty? | 4 | 3 | 2 | 1 | 0 |
| c. being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you? | 4 | 3 | 2 | 1 | 0 |
| d. thinking or feeling that people are watching you, following you, or out to get you? | 4 | 3 | 2 | 1 | 0 |
| e. video game playing or internet use that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events? | 4 | 3 | 2 | 1 | 0 |
| f. gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home or social events? | 4 | 3 | 2 | 1 | 0 |

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**Client Signature (typed) Date**

**Once this form has been completed, please send it to our Director of Clients Services, Laurie Burns at** [***info@terradynewellness.ca***](mailto:info@terradynewellness.ca)***.* If you have any questions or concerns, please give us a call at 902-889-2121.**