

**SALVATION ARMY
MAXWELL MEIGHEN CENTRE
TURNING POINT ADDICTION REHABILITATION PROGRAM
135 Sherbourne Street Toronto, ON M5A 2R5
Tel: (416) 366-2733 Ext. 233 Fax: (416) 366-6984**

Application for admittance to the Turning Point/Harbour Light Addiction Rehabilitation Program.

Name: _____ Middle: _____ Surname: _____

DOB _____ SIN: _____ OHIP: _____

Canadian Citizen Landed Immigrant Refugee Visitor

Present or last Address: _____

Length of Stay: _____

Marital Status: Married/Common Law Single Separated Divorced Widower

Primary Language: _____ Secondary Language: _____ Last

Grade Completed: _____

Presenting Issues: examples, Alcohol, Drugs, Court, Medical Condition, Psychiatric Condition, Housing etc 1. _____

2. _____

3. _____

4. _____

5. _____

Have You Been To The Turning Point Before: Yes No Date (s): _____

Length Of Stay: _____

Reason for leaving: _____

Other Treatment Program(s): example Harbour Light Yes No Date (s): _____

Length Of Stay: _____

Reason For Leaving: _____

IN CASE OF EMERGENCY

Next of Kin or Contact Person: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Other: _____

SOURCE OF INCOME

Please Indicate Your current source of Income:

No Income Employed Employment Insurance GWA/OW FBA CPP Other
Pension Insurance Other:

If you have a source of income you are required to pay for your treatment

SPIRITUAL ACKNOWLEDGEMENT

I, _____, fully understand that the Salvation Army Turning Point Program is a Christian Organization and that spirituality is practised and taught as the foundation or recovery from substance abuse at this centre. I also

understand that the classes, groups and individual counselling I will receive at the Turning Point Program will be based on this spiritual foundation.

Please inform us if you are of another religious denomination or spiritual background. The Turning point program staff will endeavour to refer you to your religious preference or faith group, if you so desire.

Yes No Name Of Religion or faith Group: _____
 No current religion or spirituality practised

By signing the Spiritual Acknowledgement section it confirms that I have read and understand the philosophy of recovery taught and practised at the Turning Point Program. My signing also confirms to the Turning Point treatment team that I accept and am willing to participate in all aspects of treatment, for my substance abuse problem, as offered by the Turning Point Program.

APPLICANT: _____ DATE: _____

ADDICTION HISTORY
Pattern Of Use

Major Substance: _____ Last Use: _____ daily binge 1-3 times 4-7 times weekly

Second Substance: _____ Last Use: _____ daily binge 1-3 times weekly 4-7 times weekly

Third Substance: _____ Last Use: _____ daily binge 1-3 times weekly 4-7 times weekly

Number of years of problem use for: **Major** _____
Second: _____
Third: _____

What situation occurred that made you aware you have a problem with the substance(s) you identified: (give month and year for each situation)

Major: _____

Second: _____

Third: _____

When you do drink, what do you usually drink: _____

If you use drugs name drug and route of administration: Drug: _____

Method of usage: _____

List all other substances used or tried in the past 12 months, including perscription medication and over the counter medication: (give dates of last use)

1	_____	4	_____
2	_____	5	_____
3	_____	6	_____

GAMBLING

Have you identified gambling as a problem for you: Yes No

What type(s) of gambling have you done:

cards horses sports casino(s) table games casino(s) slot machines bingo pull tabs
 lotteries stocks dogs

MEDICAL HISTORY

1. Last Time you saw a doctor: (give date, name) _____ Reason: _____
2. Hospital admission: (give date(s) for the past 5 years) _____

3. Are you currently perscribed medication(s): Yes No Yes, but not currently taking
List Medication(s): _____ Dose: _____ Diagnosis: _____
_____ Dose: _____ Diagnosis: _____

What method do you have for obtaining your medication? _____

4. Other health concerns you currently have: _____

5. Any History Of:

Alcohol Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____
Drug Seizures or Psycosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____
D.T.'s	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____
Lung Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____
Hepatitis- Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Episode: _____

Have you ever had TB disease? Yes No

If yes, what medication did you take?

How many pills? _____ and for how long? _____

Do you currently have Active TB for which you are currently being treated?

6. Any pending medical appointments: Yes NO Date and Reason: _____
Doctors Name: _____

Address and phone Number: _____

7. Any medical problems that need attention at the present time: Yes No

Problem: _____

Treated before: _____

PSYCHIATRIC HISTORY

1. Have you ever seen a psychiatrist: Yes No

Reason: _____ Date: _____
Psychiatrist Name: _____
Address and Phone Number: _____
Date of last visit to any psychiatrist: _____

2. Have you ever been admitted to a psychiatric facility: Yes No
Reason: _____ Date: _____
Psychiatrist Name and Facility Name: _____
Address and Phone Number: _____
3. Have you ever attempted suicide: Yes No
Give date(s) and a brief explanation: (starting with the most recent episode) _____

4. Have you ever had suicidal thoughts: Yes No
Give date(s) and a brief explanation: (starting with the most recent episode)

5. Have you had suicidal thoughts in the past 6 months: Yes No Date: _____
How did you deal with that episode? _____
6. Do you think you need to see a psychiatrist Yes No
7. Are there any problems you are aware of that need immediate attention? If yes please indicate:

CORRECTIONAL HISTORY

1. Are you on Bail Probation Parole Immigration Other (specify)
Name of Supervisor: _____
Reporting Office: _____
Reporting Days: _____
2. List charges, including Probation Orders, Conditional Orders, Family court etc...:
Reason for court date: Trial Set date Sentencing OTHER (specify)
3. List Previous convictions: _____

4. History of Violence Yes No
5. Have you been tested for TB while in Custody? _____ Result? _____

IF PRESENTLY INCARCERATED, PLEASE FILL IN THE FOLLOWING SECTION:

1. Name of Correctional Institution: _____
Address of Institution: _____
Means of Release: Bail Parole Probation Completed Sentence
Expected date of release: _____

PLEASE NOTE:

A client accepted into this program is expected to arrive at this Centre for intake into the program before 3p.m on the date of his release whether it is the date provided above or another date that has been supplied to us.

I have had the The Turning Point Point/Harbour Light Programs explained to me. I agree that I am willing to attend this program for a minimum of 28 days, and afterwards be transferred to the second phase of the program at the Harbour Light Centre.

I also understand that the 28 days can be restarted or extended if I breach any part of the program rules.

APPLICANT: _____

DATED: _____

SOCIAL ASSESSMENT

Please answer the following questions as thoroughly as possible:

1. What occurrence or situation prompted you to seek treatment at this time?

Check the item that apply to your decision to seek treatment:

- it was strictly my own idea without pressure from anyone
- a judge mandated me here
- a bail/probation officer mandated me here
- a doctor told me I needed help
- my family/friends pressured me to get help

2. Who referred you to Turning Point?
What did they tell you to expect from this program?

2. Chemical use: please answer the following questions about your using habits.

How frequently did you use drugs/alcohol? _____

Where and with whom did you use drugs/alcohol? _____

Describe your usual style of using (binge, a run, daily at same time, location etc)? _____

What discomfort have you experienced from using or drinking:

- Tension/Nervousness Stomache pain or discomfort
- Head Other: _____

Describe what you remember about your first encounter with drugs or alcohol?

What lead to your first encounter?

FAMILY ALCOHOL USE HISTORY

Indicate which of your family members have now or previously experienced problems with alcohol or drugs.

- Mother
- Father
- Brother (how many)
- Sister (how many)
- Life Partner
- Other

What influence do you believe the using habits of your family has had upon your personal development and your own addiction?

Marital/Family Relations:

What is your martial status and how long have you been in this relationship?

Does your partner drink or use drugs?

Does your partner support your efforts at recovery, expecially treatment?

Is your partner interested in being actively involved in your treatment?

Do you have children?

How would you describe your relationship with your chidren?

How would you describe your relationship with your parents?

How would you describe your relationship with your siblings?

How would you describe your relationship with other people in your life?

Accommodation:

What were you accommodations just prior to entering treatment?

Can you return to your previous accommodation?

Can you return to your family?

How stable has your housing been in the past year?

Were you living alone or with friends or family?

List your addresses during the past two years?

Vocational/Educational:

How have you supported yourself and/or your family in the past year?

What is your current work status?

How satisfying do you find your current work status?

How many months have you been employed part-time or full-time during the past year, including training/student career?

How many jobs have you had in the past 12 months?

If you currently employed can you return to work after treatment?

What is your level of education?

Social Relationships:

How many close friends do you have at present?

Are these friends a positive or negative influence on you?

Are there friends mostly drinking or using buddies or do you have a significant variety of friends?

Do (did) you drink/use mostly with co-workers, or outside your work context?

Leisure Activities:

List your normal leisure activities?

Describe your usual circumstances when you experience boredom?

What connection do you see between boredom and using alcohol or drugs?

BIOLOGICAL ASSESSMENT

Physical Health Concerns:

List all the specific health concerns you are aware of

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever experienced blackouts, seizures or D.T.'s from alcohol use: Yes No

If yes which ones have you experienced: _____

What significant illness, injuries or medical condition have you ever experienced: _____

Previous Treatment for Addiction:

Type	When	Outcome + / -
<input type="checkbox"/> Antabuse, Temposil	_____	<input type="checkbox"/> helpful <input type="checkbox"/> not helpful
<input type="checkbox"/> Valium, Librium	_____	<input type="checkbox"/> helpful <input type="checkbox"/> not helpful
<input type="checkbox"/> Individual Counselling	_____	<input type="checkbox"/> helpful <input type="checkbox"/> not helpful
<input type="checkbox"/> Alcoholics Annoymous	_____	<input type="checkbox"/> helpful <input type="checkbox"/> not helpful
<input type="checkbox"/> Group Therapy	_____	<input type="checkbox"/> helpful <input type="checkbox"/> not helpful
<input type="checkbox"/> Group Residence	_____	<input type="checkbox"/> helpful <input type="checkbox"/> not helpful
<input type="checkbox"/> Salvation Army Treatment	_____	<input type="checkbox"/> helpful <input type="checkbox"/> not helpful

List any other treatment experience during the past three years:

EXPECTATION AND GOALS

What do you hope to achieve from being in treatment?

How strong is your commitment to being in treatment?

CHOICE OF TREATMENT GOALS:

Treatment Goals	I Want Help	I Don't Want Help	Not A Problem
Physical health problems			
Seeing a doctor			
Improving eating habits			
Ability to sleep			
Dealing with seizures			
Dealing with hearing loss			
Learning to relax			
Handling negative situations			
Dealing with depression			
Handling feelings of guilt			
Seeing a psychiatrist			
Dealing with thoughts of Suicide			
Dealing with self doubts			
Handling your temper/anger			
Learning to be assertive			
Overcoming alcohol dependence			
Overcoming drug dependence			
Dealing with friends who abuse			
Learning to say NO to a drug/drink			
Avoiding relapse			
Learning how to use AA			
Finding a sponsor			
Problem solving with my spouse			
Expressing feelings with spouse			
Handling my role as a parent			
Problem solving with my children			
Being less dependent on others			
Dealing with my sexual expectations			
Obtaining marital Counselling			
Being able to speak clearly			
Learning how to budget my income			
Obtaining stable income			
Being more financially secure			
Obtaining Legal advice			
Speaking to a lawyer			
Understanding my spiritual beliefs			
Finding a pastor/religious figure			
Speaking to a pastor/religious figure			
Dealing with employment problems			
Advancing my education			
Possible vocational training			
Feeling comfortable in social settings			
Introduction to social activities			
Issues of being a victim of physical abuse			

Issues of being a victim of emotional abuse			
Issues of being a victim of sexual abuse			

I _____ have answered these questions to the best of my ability, and provided information that is truthful. I acknowledge that this information is being obtained in order to make an assessment in regards to my admission into The Turning Point Program. I also declare that I understand the Turning Point Program, and that I am agreeing to attend for a minimum of 28 days. After which I understand that I could be transferred to the Harbor Light for further assessment. I further agree that I will act in accordance with the rules and regulations of the Turning Point if I am accepted into the program.

Applicant: _____

Witness _____

Date: _____

OFFICE USE ONLY

Admission date: _____ Projected discharge date: _____

Room number: _____ Bed Number: _____

Intake staff signature: _____