First Nations Restoration Center
Program Application Form

313 Sanders Rd. West
Sioux Lookout, On P8T 0A7
T: 807-582-0138 **F:** 807-582-0139
E: firstnationsrc@yahoo.ca

A: GENERAL INFORMATION

PERSONAL INFORMATION

First Name:		Last Name:	
Preferred Name (Nickname):		Date of Birth: (mm/dd/yyyy)	
Health Insurance Number:		Province Issued:	
Address (home):		Province:	
City/Town		Postal Code:	
Contact Phone Number:		Email:	
Status Indian (yes/no):		First Nation Band Number:	
Educational Level:	___Grade 1-6 ___ Grade 6-9 ___ Grade 9-12 ___Post-Secondary		
Current Employment:	___Full Time Job ___ Part-Time Job ___ Unemployed ___ Seasonal ___ Student ___ Social Assistance ___ Disability		

EMERGENCY CONTACT INFORMATION

Name:		Relationship:	
Address:			
Home Phone:		Work Phone:	
Fax Number:		Email:	
What is the best way to contact this person?			

FAMILY INFORMATION

Marital Status:	___Single ___Married ___Common Law ___Widowed ___Divorced ___Separated		
Family Type:	___Living Alone ___With Spouse ___ With Spouse and Children ___ With Friends ___ Single Parent with Children ___With Extended Family ___ Other *If other please describe:*______________________________		
Number of Children:		Ages of Children:	
Do your Children Live with you? (yes/no)		If not all your children live with you, how many do?	

B: SUBSTANCE ABUSE PROFILE

SUBSTANCE USED:

Please provide a letter beside each applicable substance.

A: Last 24 Hours   B: 2-7 days   C: 8-30 days   D: Over one month   E: Over one year

___Alcohol
___ Cocaine
___ Crystal Meth
___ Antidepressants
___ Morphine

___ Marijuana
___ Tobacco
___ Heroin
___ Prescription Drugs
___ Inhalants

___ Crack Cocaine
___ Ecstasy
___ Talwin and Ritalin
___ Hallucinogens
Other: _____________________

Which is your drug of choice? ____

What is your pattern of use? ____

Is there any history of alcohol/drug use in your family of origin? ___Yes ___ No

If yes, please explain: ____

Do you have any of the following other addictions?

___ Gambling ___ Sex ___ Other: ________________

___ Relationship (s) ___ Food

___ Workaholic ___ Shopping

Are you now, or have you ever been an IV user? ___Yes ___ No

As of today, when was the last use of any alcohol/drug? ____

What Type?	How Much?
1.	
2.	
3.	

C: SOCIAL PROFILE

Have you attended treatment previously? ___ Yes ___ No

If "yes", please explain:

Year	Name of Centre & Location	Completed?	Drug (s) treated for:
		___yes ___no	
		___yes ___no	
		___yes ___no	
		___yes ___no	

In what way is your drinking or drug use a problem for you?

What is the longest period you have able to stay free of substances?____________________________________

What enabled you to remain free of substances at that time?

Why are you seeking treatment at this time?

___To get children back

___ Family Pressure

___ Court order

___ Condition of Employment

___ Other: please explain: ____

Do you have custody of any minor children (under the age of 18)? ___ Yes ___ No

If yes, what are your plans for your children while you are in the program?

What are your expectations of the program?

Please describe three (3) specific goals that you would like to accomplish while at the First Nations Restoration Centre (FNRC).

1.

2.

3.

List any problems you have that could affect your time at FNRC?

Have you ever been refused treatment or terminated from treatment? ___ Yes ___ No

If yes, please explain:

Did you or any member of your family attend a residential school? ___ Yes ___ No

Please Provide Details:

____

____

____

Are you presently involved with any other agencies, church group (i.e. Outpatient Counselling, Pastoral counselling, NNADAP, AA etc.) that may provide continued support to you when you leave FNRC?

___Yes ___ No

If yes, please list agency and/or church group:

____

____

____

May we involve these support agencies/churches in your planning: ___ Yes ___ No

If yes, please provide contact information:

Agency	Contact Name	Phone Number

D: LEGAL HISTORY

Have you ever been convicted of a crime? ___Yes ___ No

Was alcohol or substances involved at the time of your offence? ___ Yes ___ No

If yes, please explain:

____

____

____

Do you have any charges pending or before the court at this time? ___Yes ___ No

If yes, what are the charges? ____

When and where is your next court appearance? ____

What is your present legal status?

___ Parole

___ Probation

___ Bail

___ Not Applicable

E: MEDICAL HISTORY

Do you have history of seizures, allergies, heart condition, or diabetes? ___ Yes ___ No

If yes, please explain:

____

Have you ever had any suicidal attempts or ideations? ___ Yes ___ No

If yes, please explain:

____

Have you ever undergone a Mental Health Assessment? ___ Yes ___ No

If yes, would you be willing to share a copy of the assessment with us? ___Yes ___ No

If yes, who provided the assessment and when? ____

Are there any other medical concerns we should be aware of? If yes, please explain:

____

____

F: REFERRAL AGENT QUESTIONAIRE

Please include a copy of your agent referral questionnaire in your application, or have them send directly to us:

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Agent Name:			
Client Name:			
Title:			
Agency:			
Address:		Province:	
City:		Postal Code:	
Phone:		Fax:	

How long have you been involved with this client? ____

In your opinion, what is motivating this client to seek treatment?

____

____

Describe in detail the most important areas for the applicant to address in treatment?

___Abandonment
___ Anger
___ Grieving
___ Sexual Abuse
___ Parenting Skills
___ Rejection
___ Residential School
___Other: ________________________________

Are you aware of any other factors in this client's life (medical/legal) that may pose a threat to other clients in treatment?___ Yes ___ No

If yes, please explain:

____

____

Has this client been referred to and denied treatment at any other Centre? ___ Yes ___ No

If yes, please explain:

____

____

Will you continue to see the client once they have completed treatment? ___ Yes ___ No

Do you have any information or suspicion that this client might have difficulties due to Fetal Alcohol Spectrum Disorder? ___ Yes ___ No

If yes, please explain: ____

____

Have you completed a SASSI or other format of addictions assessment? ___ Yes ___ No

If yes, please include a copy along with this application.

Referral Agent Oath:

I certify that the information contained in this section is true, to the best of my knowledge.

Signature: ________________________________ Date: ______________________________

G. PRE-ENTRANCE MEDICAL FORM (MUST BE COMPLETED BY RN OR MD)

Please include a copy of your Pre-entrance medical form in your application, or have them send directly to us:

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CLIENT INFORMATION

First Name:		Last Name:	
Health Card Number:		Version Code:	
Province Issued:		Patient date of birth:	
Current Address:		City/Town:	
Province:		Postal Code:	
Contact Phone Number:		Town/First Nation	

Please check if client is currently being treated for or if they have a history of any of the following:

1. Does the applicant have any allergies?
   __ Mild ___ Life Threatening - Details: ____
2. Has client been diagnosed with any mental illness?

___ADHD
___Anxiety
___ Bi-Polar
___ Depression
___ Other: ____

___ OCD
___ PTSD
___ Schizophrenia

Details: ____

____

3. Any medical conditions?

___Asthma
___Emphysema/other Lung Problem
___Blood Pressure
___ Cancer
___ Diabetes
___ TB

___ Back Pain
___ Epilepsy
___ GI
___ Heart
___ Pneumonia
___ Stroke
___ Ulcer

___ HIV/AIDS
___ Hepatitis
___A
___ B
___ C
___ Scables
___ Lice

Details: ____

4. Any physical condition (s) that may hinder the applicant from normal physical activities?
____
____

5. Medications currently prescribed and reasons for use:
____
____

6. Special diet:____
7. Current/updated immunizations? ___ Tetanus ___ Influenza
8. General appearance and development (include signs of drug abuse)

Head:	
Nutrition:	
Skin:	
Other:	

Exam Date (mm/dd/yyyy):_______________________________

RN/MD Signature: _____________________________________

By signing this form I give authorization for any medical information to be released by the RN/MD.

Client Signature__________________________________ Date (mm/dd/yyyy):_________________