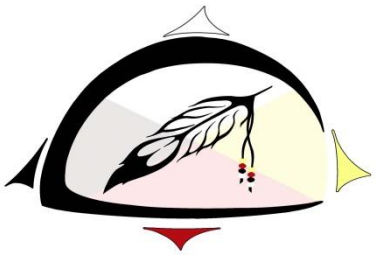

Wolastoqewiyik Healing Lodge

13309 Rt. 105 Tobique First Nation E7H 5K1
Tel: (506) 273-5403 Fax: (506) 273-4286

Atlantic Region Application & Medical Clearance Form

Name _____ **AKA** _____

First Nation_____Band/Reg#_____

Medicare #_____

DOB:_____ Age_____ Gender: Male ____ Female _____

Mailing/Civic Address _____

Province: _____Postal Code_____

Home # ( )_____Cell#( )_____Other #_____

Ethnic Background: Mi'kmaq _____ Maliseet _____Passamaqoddy _____

Innu_____ Inuit_____ Other_____

Marital Status:

Married/Common Law _____ Single/Separated _____Divorced _____

Emergency Contact Information:

Name: _____Relationship_____

Mailing/Civic Address _____

Province: _____Postal Code_____

Home # ( )_____Cell#( )_____Other #_____

Family Background:

Father's Name _____Age____Deceased: Yes ____No ____

Province: _____Postal Code_____

Home # ( )_____Cell#( )_____Other #_____

Mother's Name _____Age____Deceased: Yes ____No ____

Province: _____Postal Code_____

Home # ( )_____Cell#( )_____Other #_____

Siblings: (Brothers and Sisters)

1_____Age_____ 5_____Age_____

2_____Age_____ 6_____Age_____

3_____Age_____ 7_____Age_____

4_____Age_____ 8_____Age_____

Children: (Biological/Adopted/Foster

1_____Age_____ 5_____Age_____

2_____Age_____ 6_____Age_____

3_____Age_____ 7_____Age_____

4_____Age_____ 8_____Age_____

Present Living Arrangement

____Alone, own residence ____No place to call home

____With parents ____Couch surfer

____Spouse no children ____Spouse and children

____Single with children in own residence

____Single with children in **shared** residence

Name of **shared** residence _____Relationship_____

Do you have a family member working in the center you are making application to? ___Yes ___No If Yes, Name of staff _____

Position _____ Relation to you _____

Relationships – (Please Circle one of the following)

What kind of relationship do you have with your:

Parents:	close	friendly	distant	hostile	no relationship
Spouse:	close	friendly	distant	hostile	no relationship
Brothers:	close	friendly	distant	hostile	no relationship
Sisters:	close	friendly	distant	hostile	no relationship
Friends:	close	friendly	distant	hostile	no relationship

Do you have family support? Yes ____ No ____

Explain_____
_____

What are your views on authority. _____
_____

Mental Health

Have you ever been assessed with a mental health condition that required professional counseling? Yes ____ No ____

If yes, for what condition_____

Name of Mental Health Practitioner _____

Date_____Location_____

Were you on any medication? Yes____ No____ If Yes, what? _____

_____for how long? _____

Have you ever attempted suicide in the past? Yes ____ No ____

How many times?_____when?_____by what means_____

Were you ever hospitalized for these attempts? Yes ____ No____

If yes, where?_____How long?_____

Did you receive help for these attempts? Yes____ No ____

With whom? _____where_____when_____

Did you know someone who has committed suicide? Yes____ No____

If yes, what relationship did they have with you?

Circle one: immediate family Extended family Friend

Do you have a history of violent outbursts? Yes____ No_____

If yes, explain _____

Were you using Alcohol/Drugs at the time? Yes____ No____

Have you had treatment for Anger Management? Yes _____No____When_____

Substance Abuse History

At what age did you begin to experiment with mood altering substances?

_____yrs-old. At what age do you feel that your use/misuse became a problem for you? _____yrs-old

What substance(s) are you currently abusing/misusing? (List all)

_____

_____

What substance(s) have you abused/misused in the past? (List all)

_____

_____

Have you ever abused solvents/inhalants? Yes____ No____ (List all)

_____

Have you ever been/currently and IV drug user? Yes____ No____ (List all)

_____

Have you ever suffered the following: (Circle Yes or No)

Withdrawal Seizures Yes No Audio Hallucinations Yes No

Delirium Tremors Yes No Visual Hallucinations Yes No

What has been you longest period of abstinence? _____

Have you ever had an alcohol or drug assessment before? Yes ____ No____

Type (ie: DUSI, SASSI) _____How long ago?_____

Treatment History

Have you ever gone to a Detoxification program for your addiction(s)?

Yes ____ No____

How long ago?_____ How many times have you been in detox? _____

Did you complete the detox program? Yes____ No____ If no, reasons for not completing._____

List the most recent **Detox** programs you have attended:

Name _____Location _____Date_____

Name _____Location _____Date_____

Have you ever attended an **In-patient Treatment** program? Yes ____ No_____

List the most recent Treatment programs you have attended:

Name _____Location _____Date_____

Completed? Yes ____ NO ____ If no, explain _____

_____

Name _____Location _____Date_____

Completed? Yes ____ NO ____ If no, explain _____

_____

Have you ever attended an **Out-patient/Day Program**? Yes ____ No ____

Name _____Location _____Date_____

Completed? Yes ____ NO ____ If no, explain _____

_____

Is this application a result of a relapse? Yes ____ No ____

How long were you clean or sober before the relapse? _____

What do you feel caused the relapse? _____

_____

Legal Issues

Have you ever been convicted /incarcerated for an offense? Yes___ No____

If yes, explain_____

_____

Name and location of institution_____

Date and duration of sentence _____

Are you currently on probation/parole? Yes ____ No _____

Length of time? _____ Charges_____

Are you presently under house arrest? Yes ____ No ____

Are you court ordered to attend a Treatment program? Yes ____ No ____

by whom? _____

Do you have any pending court dates? Yes ____ No ____ If yes, give details of charges, date, location of court _____

_____

If you have upcoming court dates, can court be set over to another date until you have completed our Treatment program? Yes ____ No ____

_____

Residential School (IRS)

Have you attended residential school? Yes ____ No ____ When? _____

Did your parents/grandparents attend residential school?

Mother Yes No When_____ Father Yes No When_____

Mother's Mom Yes No When_____ Father's mom Yes No When _____

Mother's Dad Yes No When_____ Father's Dad Yes No When_____

Did your siblings attend residential school? Yes No When_____

Name of Referring Contact/Case Manager in this individual's community

Name of person _____

Agency_____

Phone# Work_____Cell#_____Fax#_____

Are there any other agencies involved with this individual? Yes ____ No _____

How many sessions have you had with your counselor? _____

If yes, please list:

Name _____Agency_____Phone#_____

Name _____Agency_____Phone#_____

Name _____Agency_____Phone#_____

In regards to planning for this client's After-Care, what community resources are available to them upon discharge? Please check all that apply

____AA	____Addiction Councilor	____Mental Health Provider
____NA	____Medical Provider	____Dental Provider
____GA	____Social Services	____Human Resources
____Al-Anon	____Sponsorship	____Child & Family
____Clergy	____ Traditional Healer	_____Support Group

Please list all other options for Follow up services that you feel would benefit your clients._____

_____

*Any person being admitted for treatment must be **alcohol and drug free for a minimum of fourteen (14) days** or have completed a recognized detox program, prior to admission.*

*All **prescribed medications must be blister packed** and turned over to center staff upon admission to our centers.*

All successful applicants will submit to searches on the person and belongings that are entering the center. Applicants will also agree to random searches of rooms and belongings if warranted by the treatment center staff.

*The referring contact/case manager will work with the Wolastoqewiyik Staff on developing the **After Care plan** for this individual applying for treatment.*

I, _____have read (above) or it has been explained to me in my first language. And that I agree to follow all rules and regulations pertaining to my admission to the Wolastoqewiyik Healing Lodge.

Applicant Signature _____Date_____

Counselor Signature _____Date_____