CREE NATIONS TREATMENT HAVEN
MATRIX INTENSIVE OUTPATIENT TREATMENT PROGRAM
APPLICATION FORM

Part 1 – General Client Information

Last Name: _____ First Name: _____

Gender: ☐ Male ☐ Female Date of Birth: [ ][ ] [ ][ ] [ ][ ][ ][ ]
Month **Day** **Year**

Status Indian: ☐ Yes ☐ No Name of Band: _____

Band Number: _____ Treaty Number: _____

Health Insurance Number: _____ Social Insurance Number: _____

Home Address: _____

Phone: _____ Email: _____

Living Arrangements [Past 6 Months]:

☐ With Family ☐ With Relatives ☐ Friends or Non-Family Members
☐ Alone [own home] ☐ Homeless ☐ Hospital, Rehabilitation Facility, etc.
☐ Correctional Facility ☐ Other: _____

Marital Status:

☐ Single ☐ Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated

Number of Children: ____ Do children live with you? ☐ Yes ☐ No If yes, how many: _____

Employment Status: ☐ Full-time Job ☐ Part-time Job ☐ Unemployed ☐ Seasonal Work
☐ Home Maker ☐ Student ☐ Other: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax Number: _____ Email: _____

B. Substance Use Profile

Substances Used:

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

Alcohol [ ] Marijuana [ ] Crack Cocaine [ ] Cocaine [ ]

Tobacco [ ] Ecstasy [ ] Crystal Meth. [ ] Heroin [ ]

Talwin & Ritalin [ ] Antidepressants [ ] Prescription Drugs [ ]

Hallucinogens [ ] Morphine [ ] Solvents/Inhalants [ ]

Other:_____

Which is your drug of choice? _____

What is your pattern of use: ☐ Daily ☐ Weekly ☐ Binges ☐ Other _____

Which of the following areas have been negatively affected by your use?

☐ School Attendance ☐ Family Relationships ☐ Physical Health ☐ Employment

☐ Psychological Health ☐ Legal Situation ☐ Other:_____

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 "Process" Addictions?

☐ Gambling ☐ Relationship[s] ☐ Shopping ☐ Workaholic ☐ Sex ☐ Other _____

Are you now, or have you ever been an IV user? ☐ Yes ☐ No

As of today, when was your last use of any alcohol/drug? _____

What Type? _____ How much? _____

Are you currently in a Methadone or Suboxone Maintenance Program? ☐ Yes ☐ No

C. Social Profile

Have you attended out-patient treatment previously? ☐ Yes ☐ No If yes, where and when?

Have you attended in-patient treatment previously? ☐ Yes ☐ No If yes, please explain?

Year Dates	Name of Centre & Location	Completed?	Drug[s] treated for
_____	_____	☐ 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 been able to stay free of substances? _____

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

_____

What motivated you to seek **MATRIX** outpatient treatment?

☐ To get children back ☐ Legal authorities [judge, parole, probation officer] ☐ Employer

☐ Family or friends ☐ Other, please explain: _____

_____

Do you have custody of any minor children? ☐ Yes ☐ No

What are the plans for your children while you are in out-patient treatment? _____

_____

What are your expectations of the Cree Nations Treatment Haven MATRIX [IOP] program?

_____

_____

Social Profile Cont.

What are your behavior patterns when you drink and/or use drugs?

☐ Aggressive ☐ Argumentative ☐ Less Shy ☐ Quiet ☐ Outgoing ☐ Withdrawn

☐ Other, please explain:_____

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 residential school? ☐ Yes ☐ No

Please provide details:_____

_____

Are you presently involved with any other agencies [i.e. Social Services, Mental Health Therapist, NNADAP, Outpatient Counselling, etc.], that may provide continued support to you when you have completed treatment?
☐ Yes ☐ No

If yes, which agencies? _____

May we involve these agencies in your case planning? ☐ Yes ☐ No
If yes, please provide contact information:

Agency	Contact name	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Legal Status

Have you ever been convicted of a crime? ☐ Yes ☐ No

What was the outcome? ☐ Incarcerated ☐ Conditional Sentence ☐ Monitor

☐ Probation ☐ Bail ☐ Temporary absence ☐ Other:_____

What is your current legal status?

☐ None ☐ On probation ☐ On parole ☐ On probation and parole

☐ Awaiting charge, trial or sentence ☐ Outstanding warrant ☐ Bail

☐ Temporary absence ☐ Other: _____

If awaiting trial or sentencing, what are the charges:_____

When and where is your next court appearance? _____

Do you have any medical history of seizures, allergies, heart conditions, or diabetes?

☐ Yes ☐ No If yes, explain:_____

Have you ever had any suicidal attempt 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 our center?

☐ Yes ☐ No If yes, who provided the assessment and when? _____

If female, are you currently pregnant? ☐ Yes ☐ No Due date:_____

Have you used any alcohol or drugs during your pregnancy? ☐ Yes ☐ No

Are there any other medical concerns we should be aware of?_____

F. Referral Agent Questionnaire

Name:_____ Title:_____

Agency:_____ Phone:_____

Address:_____ Email:_____

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 factors in this client's life [medical/legal] that may pose a threat to other clients in treatment?

☐ Yes ☐ No If yes, please explain:_____

Is out-patient treatment part of a condition for this client? ☐ Yes ☐ No

If yes, a copy of a conditional order must accompany this application.

Will you continue to see the client once he/she has completed treatment? ☐ Yes ☐ No

Do you have any information or suspicion this client has a cognitive disability ☐ 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.

Do you require a discharge summary report? ☐
Yes ☐ No

Referral Agent Oath:

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

Signature:_____ Date:_____