Opioid Treatment Therapy Program

Ahtahkakoop First Nation
Pelican Lake First Nation
Witchekan Lake First Nation
Big River First Nation

File Cover Sheet

Name: ____

D.O.B.: ______________________ PHN#:_________________________

Sex: ☐ Male ☐ Female

Status#:_____________________

Start Date:________________Transfer: ☐ Yes ☐ No ☐ New Client

Transfer From: ____

Methadone Dr.:____

Have you been in the program before? : ☐ Yes ☐ No

If yes, reason for discharge:____________________________________

Restart Date: ____

Discharge Date: ______________________

Terminated by Staff: ☐ Yes ☐ No

If yes, Reason : ____

Terminated by Client: ☐ Yes ☐ No Discharge Date: ______________

Reason for Discharge: ____

Opioid Threatment Thereapy Program Assessment

Date: ________________

Name : ____

Address: ____

Phone: _____________________ Alternate Phone: __________________________

Age: ___________ D.O.B. __________________ PHN: _____________________

Status: _____________________ Status #:______________________________

What made you decide to come to the Methadone treatment at this time?:

____

____

____

Have you been on Methadone Treatment Before?: Yes No

Where?: ________________________ How long?:___________________________

Prescribing Doctor:____

Reason for no longer being on Methadone? :

____

____

____

Chemical Dependency History

Age of initial use: _______________

Drugs used :	Daily	Weekly	Occasionaly
Alcohol			
Pot			
Phencyclidine			
Crystal Meth			
Ecstasy			
Talwin			
Ritalin			
Valium			
Restoril			
Cocaine			
Morphine			
Dilaudid			
Heroin			
Coedine			
Demoral			
Non prescribed Gabapentin			
Hydro-Morphine			
Other			

Initial age of IV use:______________

Means of supporting your Habit: ___________________________________

Number of times at Detox: __________

Number of times at Inpatient Treatment:___________________

Where: ____

Attendance at AA/NA: _______________

Withdrawal Symptoms : ____

Medical/Physical History

Family Doctor:______________________________

Do you have disease or illnesses:___________________________________

Are you receiving treatment for illnesses: _________________________

Are you pregnant: Yes No

Last time seen by Dr.:__________________________

Reason for visit: ____

Last physical exam:_________________________________

Psychological/Emotional Functioning

Have you ever been seen by a Doctor or Counselor for psychological or emotional problems?

____

Have you ever:

Experience serious depression? Yes No

Experienced serious anxiety or tension? Yes No

Experienced thoughts of suicide? Yes No

Attempted Suicide? ____

Have you thought about suicide in the last few days?_______________

Experienced trouble controlling violent behavior?__________________

Been Abused?

Physical Emotional Sexual

Social Issues

Family/Primary Relationships

Married Common Law Single Divorced Separated

Living Arrangements: ____

Partnership:

Is your Partner using: Yes No

Are they Supportive: Yes No

Children: Yes No

Are your children using: Yes No

Are they Supportive: Yes No

Is Family Service involved: Yes No

If yes, Name of worker: ____

Financial

Are you employed: Yes No

If yes, Where: _________________ How long:________________________

Income Assistance: Yes No

If yes, name of worker:__________________________________

Education

Grade: 7 8 9 10 11 12

Post Secondary ____ University_____

Skills : _____

Legal

Previous Charges____ Upcoming Pending Charges_____ No Charges_____

____

Cultural Involvement

Previous Involvement_____ No Involvement _____ Plans to get involved______

Comments: ____

____

____

Goals:____

____

____

Case Managers Comments: ____

____

____

___________________________	______________________________
Client Name (Print)	Client Signature
___________________________	______________________________
Case Manager (Print)	Case Manager Signature