

# APPLICATION & SCREENING FORM

**OFFICE USE ONLY**

Referral Date:		Referral Taken By:	
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**Instructions for completing this form:** The following form is required to begin the application process to Stonehenge. It must be printed off and completed by hand. Once completed, the applicant must contact Stonehenge Admission staff to set up an Assessment appointment. For our Women's Program, please contact Michelle Moir, Women's Admission Coordinator, at (519) 837-1470 x226 or [mmoir@stonehengeetc.com](mailto:mmoir@stonehengeetc.com). For our Men's Program, please contact Christine (Chris) Deckert, Men's Admission Coordinator, at (519) 837-1470 x227 or [cdeckert@stonehengeetc.com](mailto:cdeckert@stonehengeetc.com).

**Personal Information**

First Name:		Last Name:	
Date of Birth:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Have you ever changed your name?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What were your initials at birth?	
Have you ever used an alias?		Health Card Number:	
Who is your Family Doctor?		Dr's Phone Number:	

**Parole Information (if applicable)**

FPS#:		Case Management Officer:	
Are you applying to Stonehenge for Parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>OFFICE USE ONLY</b>	
If yes, please indicate type:	<input type="checkbox"/> Provincial <input type="checkbox"/> Day Parole <input type="checkbox"/> Full Parole	<input type="checkbox"/> Health	
What is your Parole Eligibility date? (dd/mm/yyyy)		<input type="checkbox"/> Provincial	
If incarcerated, what institution are you currently at?		<input type="checkbox"/> Federal	

**Contact & Background Information**

Home Address:		City:		Province:	
Postal Code:		Phone # :		Okay to leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact:		Relationship:		Phone # :	
Marital Status:	1. <input type="checkbox"/> Married/Common Law		2. <input type="checkbox"/> Single (never married)		
	3. <input type="checkbox"/> Widow/Widower		4. <input type="checkbox"/> Divorced/Separated		
Employment Status:	1. <input type="checkbox"/> (Self) Employed Full-time		2. <input type="checkbox"/> Employed Part-time		3. <input type="checkbox"/> Unemployed (looking)
	4. <input type="checkbox"/> Student/Re-training		5. <input type="checkbox"/> Disabled		6. <input type="checkbox"/> Not in Labour Force
	7. <input type="checkbox"/> Retired				
Preferred Language:		Other Languages?			
Source of Income:	<input type="checkbox"/> Work/Self-employed		<input type="checkbox"/> Family Support		<input type="checkbox"/> Ontario Works (OW)
	<input type="checkbox"/> Ontario Disability (ODSP)		<input type="checkbox"/> Other (please describe in next box)		
Cultural Identity: (check up to 2 boxes)	<input type="checkbox"/> English <input type="checkbox"/> North American Indian <input type="checkbox"/> French <input type="checkbox"/> Other:				

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Education: (highest level achieved)	1. <input type="checkbox"/> No formal schooling	2. <input type="checkbox"/> Some Primary School
	3. <input type="checkbox"/> Completed Primary School	4. <input type="checkbox"/> Some Secondary or High School
	5. <input type="checkbox"/> Completed Secondary or High School	6. <input type="checkbox"/> Some College/CEGEP/Nursing program
	7. <input type="checkbox"/> Completed College/CEGEP/Nursing	8. <input type="checkbox"/> Some University (not complete)
	9. <input type="checkbox"/> Completed University Degree/Masters/PhD	88. <input type="checkbox"/> Unknown

## Previous Drug Treatment

Have you had previous drug treatment?  Yes (if yes, please complete chart below)  No

Treatment Facility / Location	Type of Treatment	Date Attended (mm/yyyy)	Program Length

Have you had previous treatment at Stonehenge?  Yes  No      If yes; Admission Number: \_\_\_\_\_

First Assessment appointment date (dd/mm/yyyy): \_\_\_\_\_      Time of appointment: \_\_\_\_\_

Please check the box(es) that explains who referred you to Stonehenge:

<input type="checkbox"/> 01. Self	<input type="checkbox"/> 17. Day/Evening Addictions	<input type="checkbox"/> 30. Non-Addictions Residential
<input type="checkbox"/> 02. Family/Friends	<input type="checkbox"/> 20. Psychiatric Services	<input type="checkbox"/> 31. Self-Help Group
<input type="checkbox"/> 03. School	<input type="checkbox"/> 21. Psychiatrist/Psychologist	<input type="checkbox"/> 32. EAP/Employer
<input type="checkbox"/> 05. Assessment Referral Centre	<input type="checkbox"/> 22. Medical Services	<input type="checkbox"/> 33. Police
<input type="checkbox"/> 07. Detox Centre	<input type="checkbox"/> 23. Community Health Centre	<input type="checkbox"/> 34. Other Legal
<input type="checkbox"/> 09. Home Detox Program	<input type="checkbox"/> 24. Physician/Private Practice	<input type="checkbox"/> 35. D.A.R.T.
<input type="checkbox"/> 11. Residential Addictions	<input type="checkbox"/> 25. Public Health Unit Nurse	<input type="checkbox"/> 36. Other
<input type="checkbox"/> 13. Supportive Housing	<input type="checkbox"/> 26/27. Community Mental Health	<input type="checkbox"/> 37. Unknown
<input type="checkbox"/> 15. Outpatient Addictions	<input type="checkbox"/> 28/29. Jail Social Service	

Please specify the agency(ies): \_\_\_\_\_

Contact Name at agency(ies): \_\_\_\_\_

## Family Background

Birth Place: \_\_\_\_\_

Family Member (name)	Relationship	Age	Do you have contact with them?	Are they supportive of treatment?	Do they abuse drugs or alcohol?

If any family members are deceased, please indicate name, relationship and date of death: \_\_\_\_\_

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Name	Relationship	Date of Death	
What was it like growing up in your family?			
Describe your current living arrangements/friendships:			
Children's' Name(s)	Age	Whom do they live with?	
Are you currently involved with any of the following services (check more than one, if necessary):	<input type="checkbox"/> CAS/CCAS <input type="checkbox"/> Native CAS/CCAS <input type="checkbox"/> Other Service	<input type="checkbox"/> Probation/Parole <input type="checkbox"/> School Counselling	<input type="checkbox"/> Community Mental Health <input type="checkbox"/> Drug Addiction Program <input type="checkbox"/> Medical Services
Please describe:			
Please describe yourself:			
Why do you want to come to Stonehenge?			
<b>Prior Convictions</b>			
Legal Status:	1. <input type="checkbox"/> No Problems	2. <input type="checkbox"/> Awaiting Trial Sentencing	3. <input type="checkbox"/> On Probation
	4. <input type="checkbox"/> On Parole	5. <input type="checkbox"/> Incarcerated	6. <input type="checkbox"/> Other

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Conditions Surrounding Treatment:	1. <input type="checkbox"/> No Conditions	2. <input type="checkbox"/> Choice of Treatment or Jail
	3. <input type="checkbox"/> Condition of Probation/Parole	4. <input type="checkbox"/> Treatment of Lose Children
	5. <input type="checkbox"/> Regain Children	6. <input type="checkbox"/> Condition of Employment
	7. <input type="checkbox"/> Condition of School	8. <input type="checkbox"/> Condition of Family
	9. <input type="checkbox"/> Other	88. <input type="checkbox"/> Unknown

Do you have CURRENT Young Offenders status?  Yes  No

Do you have any charges, fines or warrants outstanding or pending?  Yes  No

If yes, please explain:

Upcoming court dates:

Please list all prior Convictions	Year	Sentence	Juvenile	Adult

Probation / Parole Officer: \_\_\_\_\_ Phone: \_\_\_\_\_

Lawyer: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever injected drugs for non-medical use? 1.  Never injected 2.  Injected over a year ago  
3.  Injected within the past year 88.  Unknown

Do you think you have a gambling problem?  Yes  No

**Health Status**

Please check any health issues that apply to you, and explain:

<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Psychiatric Diagnosis
<input type="checkbox"/> Physical Health	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Communicable Diseases (eg. Hepatitis, HIV)	<input type="checkbox"/> Mobility Concerns
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Other:

Please explain:

Do you have any allergies? (please describe)

Please list all current medications: \_\_\_\_\_ And your current dosage: \_\_\_\_\_

1 <sup>st</sup> :		
2 <sup>nd</sup> :		
3 <sup>rd</sup> :		
4 <sup>th</sup> :		

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5 <sup>th</sup> :		
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6 <sup>th</sup> :		
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Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	
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Have you ever overdosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	
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### Current Drug Use

What is/are your current drug(s) of choice? Please list in order of severity.	Please also indicate how often you used in the last 30 days for each drug.
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1 <sup>st</sup> :	<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times in past 3 weeks <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3-6 times/week <input type="checkbox"/> Daily use <input type="checkbox"/> Binge use <input type="checkbox"/> Unknown
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2 <sup>nd</sup> :	<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times in past 3 weeks <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3-6 times/week <input type="checkbox"/> Daily use <input type="checkbox"/> Binge use <input type="checkbox"/> Unknown
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3 <sup>rd</sup> :	<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times in past 3 weeks <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3-6 times/week <input type="checkbox"/> Daily use <input type="checkbox"/> Binge use <input type="checkbox"/> Unknown
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4 <sup>th</sup> :	<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times in past 3 weeks <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3-6 times/week <input type="checkbox"/> Daily use <input type="checkbox"/> Binge use <input type="checkbox"/> Unknown
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5 <sup>th</sup> :	<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times in past 3 weeks <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3-6 times/week <input type="checkbox"/> Daily use <input type="checkbox"/> Binge use <input type="checkbox"/> Unknown
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6 <sup>th</sup> :	<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times in past 3 weeks <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3-6 times/week <input type="checkbox"/> Daily use <input type="checkbox"/> Binge use <input type="checkbox"/> Unknown
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How old were you when you first tried any drug or alcohol?	
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How old were you when you first tried your current drug of choice?	
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Please indicate ANY substances used in the past 12 months:

Substance	Date Used	Method of Drug Use	
<input type="checkbox"/> None			
<input type="checkbox"/> Cannabis		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Amphetamines		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Prescription Opioids		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Cocaine/Crack		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Barbiturates		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> OTC Codeine Prp		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Alcohol		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed

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<input type="checkbox"/> Glue/Inhalants		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Benzodiazepines		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Other psycho-active substances		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Tobacco		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Heroin/Opium		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Hallucinogens		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Other:		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed

Thank you for completing the Stonehenge Application & Screening Form. Please call the appropriate Admission Coordinator as outlined in the instructions at the top of this form. If necessary, leave a message and we will respond as soon as possible.