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Please indicate which program you are applying for:

☐ Individual Residential or ☐ Family Residential

Alcove
Addiction Recovery for Women

Pronoun: ☐ She/Her ☐ Them/They ☐ She/They

Name: ____
First Middle Last

Maiden Name: ______________________ Aliases: ______________________
First Middle Last

Address: ____
Apartment & Street Number City & Province Postal Code

Home Phone: ______________________ Cell Phone: ______________________

Email address: ______________________

Alberta Health Care Number: ______________________ Date of Birth (YYYY-MM-DD): ______________

HOUSING

What is your current living arrangement?
☐ Rough Sleeper (unsheltered homelessness) ☐ Shelter (sheltered homelessness) ☐ Renting ☐ Homeowner
☐ Semi-housed (living with friends or family) ☐ Treatment Centre ☐ Detox

What ethnic group do you identify yourself with? (Please circle): African, Asian (E/SE), Asian Indian, Caucasian, Inuit, Latin American, Metis, Middle East/Arab, Mixed Race, Status First Nation, Non Status First Nation, Other
What is your first language (mother tongue)? ______________________ (i.e. English, French, Cree, Blackfoot, etc)

REFERRAL SOURCE (Who referred you to Alcove?)
☐ AA Community ☐ AHS ☐ Access Mental Health ☐ Community Organization ☐ Counsellor
☐ Employer ☐ Family/Friend ☐ Hospital ☐ Legal/Justice ☐ Physician ☐ Recovery Access
☐ Self ☐ Other ______________________

Referral Source Name: ______________________ Referral Source Agency: ______________________
Phone: ______________________ Fax: ______________________

Are you required to attend treatment by any of the following?
☐ Children's Services ☐ Employer ☐ Drug Court ☐ Probation ☐ Parole ☐ Other: ______________

INCOME SOURCE
☐ Employed ☐ Alberta Works ☐ AISH ☐ Employment Insurance ☐ On-Reserve Income Assistance
☐ Other Assistance ☐ Other source of income ☐ No income ☐ No income, performing unpaid work
If Applicable: AISH Benefits Number: ______________________ Treaty Number: ______________________
Alberta Works / Alberta Supports Number: ______________________

EMPLOYMENT STATUS
☐ Employed ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disability ☐ Not in labour force

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EDUCATION

What is your highest level of education?

☐ Gr. 1-9 ☐ Gr. 10-12 ☐ Some Post-Secondary ☐ University Degree ☐ College Diploma/Degree

ALCOHOL AND DRUG HISTORY

Please list any substances that you have abused (past and present), including drugs, alcohol, solvents, prescriptions, over the counter medications, etc.)

Type of Substance	Amount Used	Pattern of Use (daily, weekly, route of administration (oral, inhaled, etc)	Last Use Date	Length of Use (i.e. 2 years)	Age Started Using

What is your primary addiction? ________________________________

What is your secondary addiction? ______________________________

Are you currently using? ☐ Yes ☐ No (When dd you stop?) __________

SMOKING HISTORY

Do you currently smoke cigarettes? ☐ Yes ☐ No Do you currently use e-cigarettes? ☐ Yes ☐ No

If yes, are you interested in quitting? ☐ Yes ☐ No

How many cigarettes do you smoke daily? ☐ None ☐ 5 or less ☐ half a pack ☐ one pack ☐ more than one pack

PROCESS ADDICTION HISTORY

Which types of gambling (past and present) you have participated in:

☐ Bingo ☐ VLTs ☐ Slots ☐ Internet ☐ Casinos ☐ Scratch tickets ☐ Cards ☐ Lotteries

Have you spent more money than you intended on any of the above activities? ☐ Yes ☐ No

Do you identify with any of these behaviors as being problematic?

☐ Gaming ☐ Internet ☐ Relationships ☐ Pornography ☐ Shopping ☐ Sex ☐ Food

TREATMENT HISTORY

Is this your first time accessing any form of treatment? ☐ Yes ☐ No

Have you previously been assessed or received treatment at Alcove? ☐ Yes ☐ No

Please list other addiction treatment programs you have attended:

AGENCY	Inpatient or Outpatient	Dates	Completion (Yes or No)

FAMILY AND SOCIAL HISTORY

What is your partnership status? ☐ Single ☐ Married ☐ Common Law/Partnered ☐ Divorced ☐ Widowed ☐ Separated

What sexual orientation do you identify yourself with? ☐ Straight ☐ 2SLGBTQ+ ☐ Unsure ☐ Prefer not to say

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Do you parent children under the age of 18? Please list all applicable children.

Name	Age	Sex	At Home? (Yes / No)	Children's Services Involvement

Have you had significant periods in which you have experienced serious problems getting along with?
☐ Partner ☐ Family ☐ Friends ☐ Co-workers

Please list all supports you have (i.e. 12 Step, family, friends, church, community agencies, etc)

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TRAUMA/LOSSES HISTORY

Have you experienced any of the following types of abuse/trauma?
☐ Sexual Abuse ☐ Financial Abuse ☐ Physical Abuse ☐ Emotional Abuse ☐ Spiritual Abuse ☐ Sex Work ☐Other
Have you experienced any of the following types of significant life losses?
☐ Death ☐ Health problems ☐ Divorce/separation ☐ Loss of a job ☐ Other

LEGAL HISTORY

Do you have any of the following legal issues:
☐ None ☐ Upcoming Court ☐ Bail ☐ Probation Order ☐ Conditional Sentence Order ☐ Parole
If yes, please provide details: ____

Do you have any outstanding legal concerns (i.e. court dates, charges, trial or sentencing) ☐ Yes ☐ No
If yes, please provide details: ____

Do you have a Guardian or Trustee Order under The Adult Guardianship and Trusteeship Act? ☐ Yes ☐ No
If yes, please provide details: ____

Guardian/Trustee's Name and Phone Number: ____

Do you have a Community Treatment Order? ☐ Yes ☐ No

MEDICAL AND HEALTH HISTORY

Are you on Kadian? ☐ Yes ☐ No
Are you on Methadone? ☐ Yes ☐ No
Are you on Naltrexone? ☐ Yes ☐ No
Are you on Sublocade? ☐ Yes ☐ No
Are you on Suboxone? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No If yes, please specify due date/ or number of months pregnant __________
If yes, have you received pre-natal care? ☐ Yes ☐ No
Do you have a family physician? ☐ Yes ☐ No
If yes, Physician Name: ____________________________ Phone: __________________ City: ____________________
Please identify any surgeries that have affected your addiction and/or have resulted in substance abuse.

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Please describe any accidents or injuries that have been directly or indirectly related to substance abuse.

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How many times in your life have you been hospitalized for medical problems? ___________________________
How long ago was your last hospitalization for a physical problem? _________________________________
Do you have any issues that require accommodation? (hearing loss, difficulty reading or writing, mobility, etc.)

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Please describe any health problems you have that may impact your participation in this program: ________________

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Chronic Pain:

Have you been diagnosed with chronic pain by a medical professional? ☐ Yes ☐ No If yes, when? ____________________

Does your pain interfere with your daily activities? ☐ Yes ☐ No If yes, how? ____________________

How do you currently manage your pain? ____________________

Do you experience trouble sleeping: ☐ Staying asleep ☐ Falling asleep ☐ Night terrors ☐ Snoring ☐ Sleepwalking

Have you been diagnosed with a sleep disorder? ☐ Yes ☐ No

PSYCHOLOGICAL AND MENTAL HEALTH INFORMATION

Are you currently involved with a mental health professional? ☐ Yes ☐ No

If yes, please specify: (i.e. psychiatrist, psychologist, therapist) ____________________

Name: ____________________ Phone: ____________________ City: ____________________

Do you have a past or current FORMAL mental health diagnosis? ☐ Yes ☐ No

If yes, when and by whom? ____________________

IF YES, please check all that apply:

☐ ADD/ADHD ☐ Anxiety Disorders ☐ Bipolar ☐ Borderline Personality Disorder ☐ Depression

☐ Dissociative Disorder ☐ Eating Disorder ☐ Obsessive Compulsive Disorder ☐ Post-Traumatic Stress Disorder

☐ Schizophrenia ☐ Other: ____________________

Fetal Alcohol Spectrum Disorder (FASD) is a medical diagnosis that describes the range of brain injuries, birth anomalies and developmental disabilities that can result when a woman drinks alcohol during pregnancy.

Have you been diagnosed with Fetal Alcohol Spectrum Disorder? ☐ Yes ☐ No

Do you suspect your mother may have been drinking alcohol while pregnant with you? ☐ Yes ☐ No ☐ Unsure

Have you ever been hospitalized for a mental health reason? ☐ Yes ☐ No

Please indicate the dates and reason for hospitalization: ____________________

Do you have a history of suicidal thoughts? ☐ Yes ☐ No

Do you have a history of suicidal attempts? ☐ Yes ☐ No

If yes, please indicate the dates and circumstances: ____________________

Have you had any involvement with self-harm in the past year? ☐ Yes ☐ No

Do you have any history of self-harm behaviors? ☐ Yes ☐ No

If yes, please indicate the dates and circumstances: ____________________

Alberta Health Care Number: ____________________ Date of Birth: ____________________ (YYYY-MM-DD)

PLEASE SUBMIT THE APPLICATION FORM VIA EMAIL INTAKE@ALCOVERECOVERY.CA OR FAX 403-242-3915