THE RECOVERY PLACE

Offices 4211 Yonge St. Suite 302
Office Line 416-939-0074
Fax Line 416-221-3760
info@therecoveryplace.ca

Where recovery grows roots…

…and life sprouts opportunities.

This form may be filled out using Adobe Reader and submitted via email. Please save a copy of completed form before submitting.

NAME: DATE:

DATE OF BIRTH: AGE:

MAILING ADDRESS:

HOME PHONE# CELL PHONE#

EMAIL OHIP #

REFERRAL SOURCE:

PRIMARY SPONSOR/GUARANTOR/PARENT/SELF/EMERGENCY CONTACT

FATHER (if applicable) PHONE

FATHER EMAIL ADDRESS

MOTHER (if applicable) PHONE

MOTHER EMAIL ADDRESS

CURRENT CLINICAL TREATMENT or SOCIAL WORKER:

PHONE# EMAIL:

TREATMENT HISTORY

| RESIDENTIAL/OUT-PATIENT | DATES |
|---|---|
| 1) | |
| 2) | |

| COUNSELING/THERAPY (NAME) | START DATE | END DATE |
|---|---|---|
| | | |

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## DRUG/ALCOHOL HISTORY

AGE:

| SUBSTANCE(S) | USE PER WEEK | QUANTITY |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |

AGE:

| SUBSTANCE(S) | USE PER MONTH | QUANTITY |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |

OTHER PROBLEMATIC BEHAVIOURS, E.G. SELF HARM, EATING ISSUES, ETC.

| | | |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |

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# MEDICAL/MENTAL HEALTH HISTORY*

1) DIAGNOSIS/CONDITION:

PRESCRIBING DOCTOR:

DOCTOR CONTACT INFO:

| PRESCRIPTION | DOSAGE | STILL TAKING BEGIN-END DATES |
|---|---|---|
| | | |
| | | |
| | | |

2) DIAGNOSIS/CONDITION: _____

PRESCRIBING DOCTOR: _____

DOCTOR CONTACT INFO: _____

| PRESCRIPTION | DOSAGE | STILL TAKING: Y/N |
|---|---|---|
| | | |
| | | |
| | | |

*PLEASE WRITE ON BACK PAGE IF MORE SPACE IS REQUIRED

NOTES/COMMENTS ON MEDICAL/MENTAL HEALTH CONDITION(S

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GOALS FOR TRANSITIONAL LIVING

COUNSELING / SOCIAL WORKER / PSYCHIATRIST:
STRUCTURED OUTPATIENT PROGRAM/ OR AFTERCARE:

LIST IF PREVIOUSLY INVLOVED IN 12-STEP MEETINGS OR PLANS TO ATTEND SELF HELP Y/N:

WORK AND/OR SCHOOL GOALS

SUPPORTIVE FAMILY AND FRIENDS

POST-TRANSITIONAL HOUSING GOALS

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ARE THERE ANY OUTSTANDIG LEGAL INVOLVEMENT/CRIMINAL CHARGES?

WHAT SIGNS WOULD YOU EXHIBIT LEADING UP TO A RELAPSE?

IF YOU WERE INVOLVED IN A SITUATION OF CONFLICT OR TIMES OF INTENSE STRESS, HOW WOULD YOU LIKE TO BE SUPPORTED?

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# RELEASE OF INFORMATION

RE:_____ DOB:_____

ADDRESS_____

I _____, GIVE PERMISSION TO JAY PASTERNACK AND THE STAFF OF RECOVERY PLACE INC. TO SPEAK WITH:

_____of_____

_____of_____

_____of_____

REGARDING MY TREATMENT PLAN AND PROGRESS

AND I _____AGREE TO HAVE:

_____of_____

_____of_____

_____of_____

RELEASE MY INFORMATION/MEDICAL RECORDS TO THE STAFF OF RECOVERY PLACE INC :

I UNDERSTAND THAT THIS PERMISSION IS GIVEN FOR THE ENHANCEMENT OF MY TREATMENT PLAN AND THAT I CAN REVOKE THIS CONSENT AT ANY TIME BY TELLING EITHER PARTY THAT THE PERMISSION IS REVOKED.

**CLIENT, PARENT or GUARDIAN**

PRINT_____SIGNATURE_____DATED_____

**WITNESS**

PRINT_____SIGNATURE_____DATED_____