

Leading Thunderbird Lodge Youth Treatment Center

Box 400

Fort Qu'Appelle, Saskatchewan

SOG 1SO

Phone: (306)332-5659 Fax: (306)332-1850



Intake Form

Clients **must** be willing to participate in treatment. Please keep in mind that more information and details that you provide, the better Leading Thunderbird Lodge can assess the needs of the client. You may fax the Intake package, however please mail in the original.

Person making referral:

Name: _____

Relationship to Client: _____

Referral Information:

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____

Date of Birth: _____ Age at present: _____

(dd/mm/yy)

Address: _____

Health Card Number: _____ Province of Registration: _____

Expiry Date: _____

Band Name and 10 Digit Treaty Number: _____

(Please include a photocopy of the client's **Health Card** and **Status Card**)

Language(s) Spoken _____

Other Agency Involvement: (i.e.: ICFS, Social Services etc.)

Agency Name: _____

Worker Name: _____ Phone #: _____

Referring Agency (please include name, address and phone number of contact):

Client Status: Permanent Ward ____ Voluntary Placement ____

Other (specify) _____

Education:

Is the client currently attending school? Yes ___ No ___

If **No**, when did client last attend school? _____

Name and phone number of last school attended: _____

Does the client like school? Yes ___ No ___

Highest grade completed: _____ Date completed: _____

Does the client have any special educational needs that our teacher should be aware of? _____

Family History:

Biological Mother: _____

Biological Father: _____

Guardian: _____

Address: _____

Phone Number: (home) _____ (work) _____

Best daytime contact phone number: _____

Place of Employment: _____

Names and ages of siblings:

Resides with Client?

- | | |
|-----------|----------------|
| 1. _____ | Yes ___ No ___ |
| 2. _____ | Yes ___ No ___ |
| 3. _____ | Yes ___ No ___ |
| 4. _____ | Yes ___ No ___ |
| 5. _____ | Yes ___ No ___ |
| 6. _____ | Yes ___ No ___ |
| 7. _____ | Yes ___ No ___ |
| 8. _____ | Yes ___ No ___ |
| 9. _____ | Yes ___ No ___ |
| 10. _____ | Yes ___ No ___ |

Religious Beliefs: Traditional ___ Other (specify): _____

Relationships:

Does the client reside with: Mother_____Father_____Siblings_____Friends_____Alone _____

Extended Family, if so, who? _____

Other (specify) _____

How does the client get along with family members? _____

Who does the client feel closest to? _____

Does the client have any close friends? (Please provide names and phone numbers)

Is the client in a romantic relationship? Yes _____ No ____

Is contact with this friend allowed while client is in treatment? Yes _____ No ____

Name and Phone # of this friend _____

Is the client sexually active? _____

Does the client talk to Elders? If yes, please provide the Elder's name and phone number

Is the client willing to listen and talk to an Elder? _____

Does the client talk to a Counselor/Therapist? _____

If yes, please provide Counselor/Therapist name and phone number.

If yes, please provide Counselor/Therapist address:

Medical History:

Does the client have any medical problems? (Please specify) _____

Name of Family Doctor: _____

Address and Telephone # of Family Doctor _____

Is the client currently on any medications? (If yes, please provide a list of all meds.) _____

Does the client have any allergies? (If yes, please specify) _____

Chemical Use History:

At what age did the client start sniffing? _____

At what age did the client start using alcohol? _____

At what age did the client start using other drugs? _____

Has the client ever used any of the following? (please be specific)

Substance	Yes	No	How long used? Months/years	How frequent?	Method Used (i.e. snort, smoke, inject)
Cocaine (Crack, powder)					
Crystal Meth					
Marijuana (specify-hash, oil etc.)					
Alcohol (Specify – beer, hard liquor, etc.)					
Solvents (specify what)					
Other (please specify any other drugs that have been taken)					

Does the client reside with any family members who use solvents and/or substances?

If so who and what? _____

How frequently? _____

Does the client use solvents/substances with others and/or alone? _____

Where does the client usually sniff/huff? _____

Where does the client usually use drugs, alcohol and/or solvents? (i.e.: school, friends homes, etc.)

Has the client ever lost friendships because of alcohol, solvent and/or drug use?

Has the client ever caused serious injury to others while on drugs, alcohol and/or solvents? _____

Does the client have any medical, physical, psychological, emotional problems because of the use of drugs/alcohol/solvents? (If so, please elaborate) _____

Does the client feel that they have lost control over the use of drugs/alcohol/solvents? _____

Has the client ever considered quitting or reducing using? _____

Psychological Functioning:

Has the client ever spoken or wrote about killing himself? (If so, please provide details)

Has the client ever attempted to kill himself? (If so, when?) _____

How many times? _____

How did the client attempt to kill himself? _____

Has the client frequently gone off on his own when he is depressed or unhappy? _____

Is the client sad/unhappy? _____

- some of the time? _____

- most of the time? _____

- all of the time? _____

Is there any known history of sexual abuse? _____

Is there any known history of physical abuse? _____

Is there any known history of emotional abuse? _____

Please explain (ie: at what age? Has it been reported and what is the outcome or current status?)

Is there any history of family violence that the client may have been witness to? (If so, please describe.)

When the client is in a sober state:

Has he communicated with spirits that no one else can see or hear? _____

Has this ever happened? _____

Are these positive or negative experiences for the client? _____

Are there times when people are unable to communicate with the client? _____

Has the client ever had any psychological testing or counseling? If so, please provide names, addresses, dates and reason _____

Outside Resources:

Are there any other agencies involved with the client and his family? If so which ones and what services do they provide? (i.e.: NNADAP, CFS, Elders, extended family, support groups, school reps, Wellness support) _____

Family:

Family activities/practices: What activities does the family currently do together? _____

How does the client spend his leisure time? _____

What effects does the abuse of drugs, alcohol and/or solvents by this client have on the family? _____

What strengths and/or talents does the client possess?

Please list any supportive persons (relatives and/or counselors) and agencies in the community that the client could have contact with to help him be successful in treatment and after treatment is completed.

Legal Issues:

Has the client ever had any dealings with the law? (If yes, please provide a list of all offences, dates and disposition)

Were drugs/alcohol/solvents involved during the client's dealings with the law? _____

Is the client currently on probation or on a court order?

Provide offence and details: _____

Name of Probation Officer: _____

Address: _____

Phone: _____

Probation Order: From _____ To _____

Conditions: _____

****ANY ORDERS MUST BE ATTACHED**