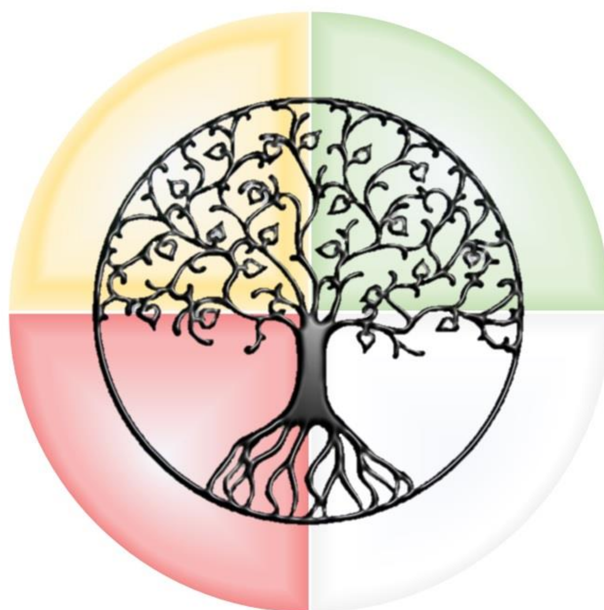
Mino Ayaa Ta Win Healing Centre

Residential Treatment

Admissions Package

To be completed **before** admissions into the program.



Residential Treatment Intake:
(807) 271-0194 PHONE
(807) 274-9941 FAX
matwintake@fftahs.org

Fort Frances Tribal Area Health Services
Behavioural Health Services

RESIDENTIAL TREATMENT SERVICES- Basic Identifying Information

Date of Completion: ___________________

First Name:	Last Name:	
Current Address:	City and Province:	
Postal Code:	Phone:	
Date of Birth: (D/M/Y)	Age:	Sex: ☐ Male ☐ Female ☐ Two-spirited ☐ Decline
Health Card #:	Email Address:	
Family Origin: ☐ First Nation ☐ Metis ☐ Aboriginal (First Nation Non-Status) ☐ Non-Aboriginal ☐ Unknown/Declined	Community: Clan: Spiritual Advisor:	
Status Card #: ☐ On Reserve ☐ Off Reserve	Preferred Language:	
Suicide Risk: ☐ High ☐ Medium ☐ Low ☐ Not Applicable/No Risk		

Referred by: If not self, please complete referral source information (next page)	Other Contacts:
Reason for Referral:	

PERSON TO CONTACT IN CASE OF EMERGENCY: This field is mandatory.

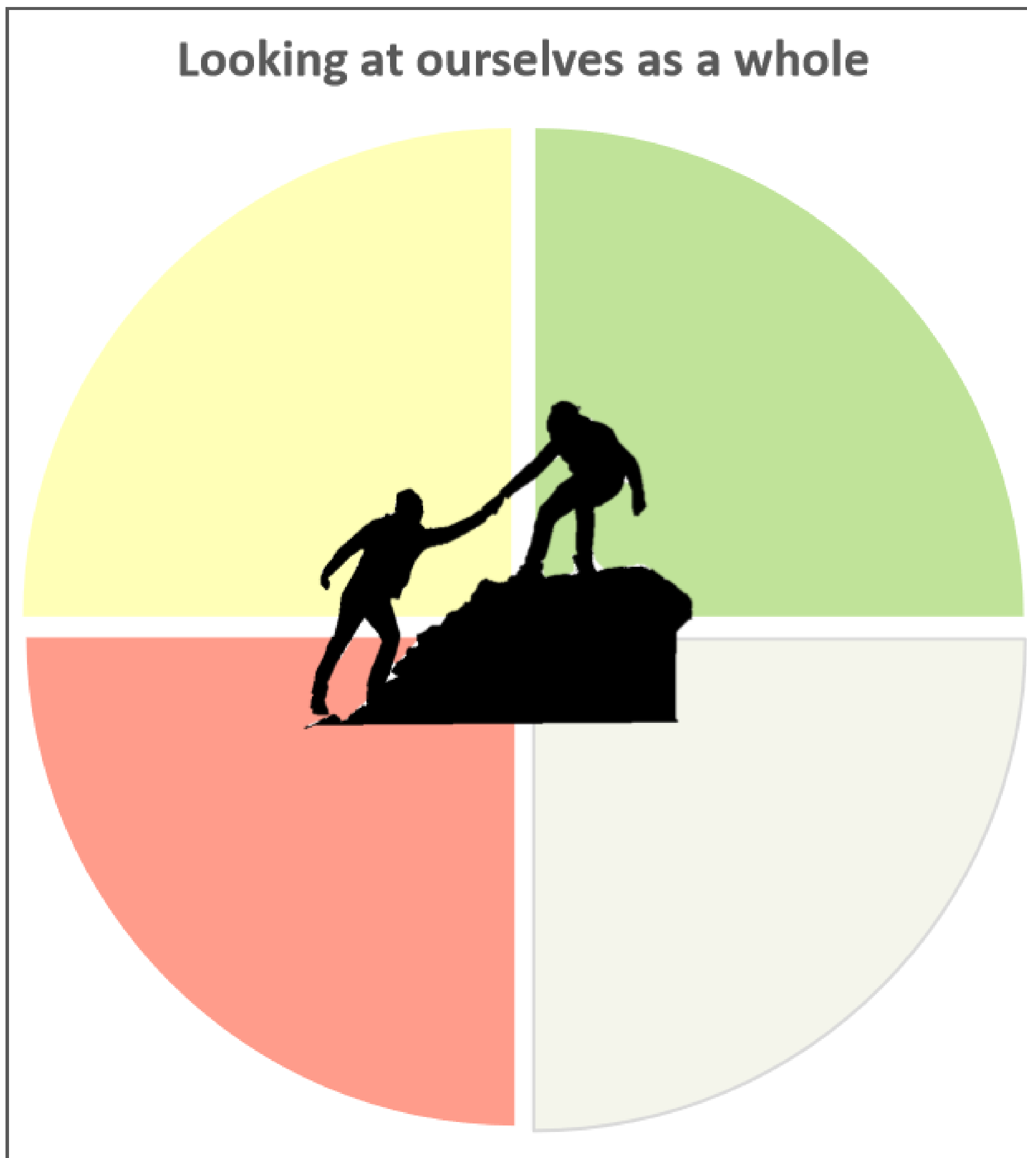
Name:	
Phone Number (Mandatory)	Relationship to Applicant:
Address:	

REFERRAL SOURCE INFORMATION

Name of Referring Person:	Position:
Agency Name and Address:	
Phone Number:	Fax Number:
What is the nature of your relationship with client? (Example: NNADAP Worker, Counselor, Advocate, Doctor, Family Member?)	
How long have you known this person?	Reason for involvement with referring person/agency?
In your opinion, what do you see as strengths at this time?	
What might you see as weaknesses or area to work on?	
To your knowledge, has the client ever experienced psychiatric or psychological problems? (If yes, please explain)	
We encourage individuals to share in Aftercare services after participation at the Healing Centre. Please list any programs and/or services available in your community for follow-up with this client.	

It is important that we care for ourselves as a whole.

As we work through this package, we will be looking at your physical, mental, emotional and spiritual self.



PHYSICAL ASPECT OF SELF

LEGAL STATUS

<table>
<tr><td colspan="3">Current/Pending Charges: ☐ Yes ☐No</td></tr>
<tr><td colspan="3">If yes, please list current charges:</td></tr>
<tr><td>In Jail? ☐ Yes ☐No</td><td colspan="2">If yes, release date:</td></tr>
<tr><td>On Probation? ☐ Yes ☐No</td><td>If yes, start date:</td><td>End date:</td></tr>
<tr><td colspan="3">Conditions:</td></tr>
<tr><td>On Parole? ☐ Yes ☐No</td><td>If yes, start date:</td><td>End date:</td></tr>
<tr><td colspan="3">Conditions:</td></tr>
<tr><td>Do you have to attend criminal court?
☐ Yes ☐No</td><td colspan="2">If yes, when and why?</td></tr>
<tr><td>Probation Officer:</td><td colspan="2">Telephone Number:</td></tr>
<tr><td colspan="3">Address:</td></tr>
</table>

PAST OFFENCES

Please indicate if you had any of the past offences listed below:
(Check all that apply and identify year of offence)

☐ Arson	☐ Impaired Driving	☐ Robbery
☐ Assault	☐ Manslaughter	☐ Sexual Assault
☐ Break and Enter	☐ Murder	☐ Theft
☐ Burglary	☐ Parole Violation	☐ Weapons Offenses
☐ Drug Charges	☐ Probation Violation	☐ Willful Damage/Mischief
☐ Forgery	☐ Criminal Negligence causing death	☐ Possession of stolen property

ADDICTIONS HISTORY

Current Drug Use: Complete this for all substances used

SUBSTANCE	LAST USE DATE/TIME	AMOUNT	METHOD USED	AVERAGE DAILY AMOUNT	LENGTH OF USE

Substances used within the past 90 DAYS:

- ☐ Alcohol
- ☐ Cocaine
- ☐ Heroin/Opium
- ☐ Marijuana
- ☐ Crack
- ☐ Glue
- ☐ Inhalants
- ☐ Suboxone
- ☐ Amphetamines (Ex. Ritalin)
- ☐ Barbiturates (Ex. Brevital)
- ☐ Hallucinogens (Ex. Ecstasy)
- ☐ Over the counter Codeine (Ex. Tylenols #1, #3)
- ☐ Methadone
- ☐ Oxycontin
- ☐ Benzodiazepine (Ex. Ativan, Valium)
- ☐ Prescription Opioids (Ex. Morphine)

Have you experienced any of the following?

- ☐ Hangovers
- ☐ Blackouts
- ☐ Vomiting
- ☐ Seizures
- ☐ Shakes
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Injection or IV Drug Use?

Are you familiar with Harm Reduction or Safe Using Practices?

First Use: ____________

Last Use: ____________

TREATMENT/DETOXIFICATION HISTORY

Please include the three most recent treatment or detox programs you have accessed.

Name of Facility	Date Attended	Completed Y/N	Program Length
How long were you clean/sober after treatment or detox?			
What was your reason for going back to drinking/using?			
What did you like about treatment or detox? Dislike?			

Name of Facility	Date Attended	Completed Y/N	Program Length
How long were you clean/sober after treatment or detox?			
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Name of Facility	Date Attended	Completed Y/N	Program Length
How long were you clean/sober after treatment or detox?			
What was your reason for going back to drinking/using?			
What did you like about treatment or detox? Dislike?			

MEDICAL HISTORY

Family Doctors Name:	Telephone:
Address:	

MEDICATIONS

Please list any medications below:

Name:	Dose:	Prescribed by:
When it started:	Reason Prescribed:	
Name:	Dose:	Prescribed by:
When it started:	Reason Prescribed:	
Name:	Dose:	Prescribed by:
When it started:	Reason Prescribed:	

Do you have any allergies? ☐ Yes ☐ No

Is an Epi-Pen Required for the above allergies? ☐ Yes ☐No

HARM REDUCTION- Reducing our risks when using**.**

Are you currently using a harm reduction model of care? Ex. Methadone or Suboxone
☐ Yes ☐ No

If yes, what is:

Your current dose: _______ Your initial dose: ________

Do you have a treatment plan? ☐ Yes ☐ No
If you do have a plan, please share your experience.

If no, would this be something of interest?

Do you have any of the following? (Please check all that apply)

- ☐ Arthritis
- ☐ Ear/Hearing Problems
- ☐ Tuberculosis
- ☐ Hernia
- ☐ Pregnancy
- ☐ Convulsions/Seizures
- ☐ Asthma
- ☐ Eye Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Head Injury
- ☐ Bowel Problems
- ☐ Stomach Problems
- ☐ Blood Pressure

*Note details below

Are there any other major health concerns that are not listed above? Or detailed information on presenting health issues.

MENTAL ASPECT OF SELF

EDUCATION

Highest grade completed:	Name of last school attended:
Have you had any learning disabilities in school?	

EMPLOYMENT STATUS

☐ Employed (FT, PT, Seasonal, Training) ☐ Unemployed ☐ Retired

INCOME SOURCE

☐ Employment ☐ Employment Insurance ☐ Ontario Works ☐ ODSP ☐ No Income

MENTAL HEALTH HISTORY

Do any of the following apply to you? (Please check all that apply)

- ☐ Tension, Anxiety, Nervousness
- ☐ Eating Disorder (Binging, Starving)
- ☐ Sexual Abuse/Assault
- ☐ Physical/Mental/Emotional Abuse
- ☐ Low Self-Esteem
- ☐ Grief Issues
- ☐ Depression
- ☐ Fears, Phobias
- ☐ Sexuality Concerns
- ☐ Anger/Aggression Problems
- ☐ Difficulty Expressing Emotions
- ☐ Sleeping Disorders

During these times, what keeps you grounded?

Have you ever had one of the following? (Please check all that apply)	YES	NO
Suicidal Thoughts		
Self-Harm Behaviours		
Attempted Suicide		

Please describe in detail (Example: what did you do, when, plan, etc.)	
Have you ever been hospitalized for a mental health issue? ☐ Yes ☐ No	
When/length of stay:	Facility:
Have you ever had counseling for a mental health issue? ☐ Yes ☐ No	
Name:	Agency:
Date:	How long:
Please indicate what issues were addressed:	
If you aren't in counseling, would this be something of interest? ☐ Yes ☐ No thanks	

LIVING SITUATION

Current Living/Housing Status:

☐ No fixed address ☐ Independently ☐ With family/partner ☐ Group home

☐ Hospital ☐ Other: ___________________

PERSONAL RISKS

Is there anything you feel that may contribute to your addiction?

☐ Environment (housing conditions, employment)

☐ Overall Health

☐ Social (Friends, peers, co-workers)

☐ Genetics (Parents/Grandparents/Guardians used alcohol or drugs)

☐ Stress/Loneliness

☐ Other: ___________________ please share.

EMOTIONAL ASPECT OF SELF

FAMILY BACKGROUND AND HISTORY

Current Marital Status:
☐ Single ☐ Separated ☐ Divorced ☐ Common-law ☐ Widowed ☐ Married

Name of Spouse/Partner:

Length of relationship:

YOUR FAMILY OF ORIGIN

Parents Names	Living	Deceased
Mother:		
Father:		
Step-Mother:		
Step-Father:		

Brothers' Names	Biological	Step/Half	Living	Deceased

Sisters' Names	Biological	Step/Half	Living	Deceased

FAMILY HISTORY

Who raised you?

☐ Parents ☐ Grandparents ☐ Extended Family ☐ Foster Parents ☐ Adoptive Parents

Do any of the following apply to your childhood? (Check all that apply)	
☐ Parental Alcohol/Drug Abuse	☐ Witness to domestic violence
☐ Witness to any kind of violence	☐ Sexually Abused
☐ Physically Abused	☐ Suicide death of family member or close friend
☐ Divorce or separation of parents	☐ Emotionally Abused
☐ Inappropriate sexual behaviours by adults? Other children? Community Members?	
☐ Did you, your parents or grandparents attend Residential School?	
If yes, which school was attended? Please describe what this experience was like for you or your family member.	

DEPENDENT CHILD(REN)

Name	Age	Where is the child now?	Parents Name

If your child(ren) are not in care, who will care for your child(ren) while you are in treatment?		
Name:	Telephone Number:	Relationship to children:
Is Weechi-it-te-win, CAS or any other Child Welfare Agency currently involved with your family? If so, please complete below.		
Name of Agency:	Telephone Number:	
Name of Worker:		

GENOGRAM- A DIAGRAM OF YOUR FAMILY

SPIRITUAL ASPECT OF SELF

BELIEFS, VALUES AND STRENGTHS

Please briefly describe your belief system.
What Traditional practices do you participate in?

STRENGTHS AND RESOURCES

What gives you hope?
What do you see as your personal strengths?

NEEDS/PRIORITIES

Is there anything you see as need while attending treatment?
Why is attending treatment important to you?

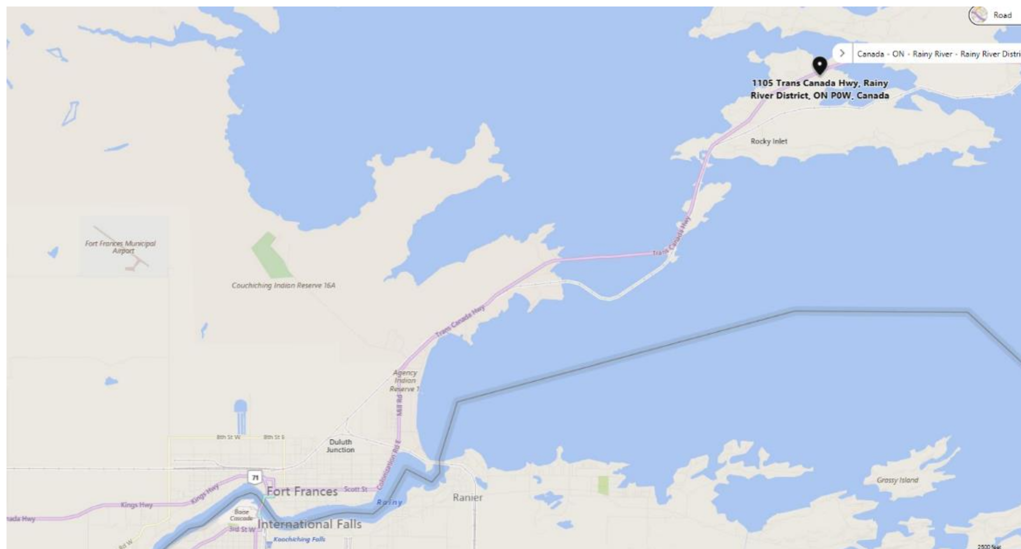
Please forward your completed package to the following:

Intake Worker:
807-271-1905 PHONE
807-274-9941 FAX
matwintake@fftahs.org

Mailing Address:
PO Box 608
Fort Frances, ON
P9A 3M9

Where can you find us?

We are located approximately five minutes East of Fort Frances on Highway 11.
Fire #1107- Mishkiki Miikan Rd.



Now what happens?

Our Intake Worker will connect with you in the next 3-5 business days to schedule an intake interview. The interview process includes reviewing your package, completing an assessment and ensuring program suitability. It's also an opportunity for potential clients to ask any questions they may have about the centre or Fort Frances Tribal Area Health Services Programs. After such interview, suitability is determined and an upcoming treatment date can be provided pending acceptance.