

Substance Use Information

Date of last use: _____

Are you currently in a substance use treatment program? Y/N

Name of Program	
Graduation date	

Past substance use support/programs:

Name of Program	Year Attended	Complete Y/N

For purposes of safety, women are not allowed to use substances while staying at PH:

1. How would this be for you? Do you have any concerns?

About past periods of no use:

2. Have you had periods of no use before? If so, can you tell us about these periods? (How long, what worked, what was hard?)

3. When/if you had a slip in the past or returned to use, what were the circumstances and/or what changes did you see in yourself?

Legal

If applicable, please provide a copy of any conditions.

Copy provided:

Medical

Do you have any serious allergies, or dietary restrictions? Please list below.

(Note: For serious allergies or dietary restrictions, please provide medical confirmation):

Please note

- Palmerston House is a home for women who have completed a substance use treatment program and desire an abstinence-based environment. Women are expected to participate in programs that support their goals as well as parenting programs, if applicable.
- Palmerston House a communal living environment and offers shared accommodations.
- Single women share a bedroom. Mothers with infants will receive a private room.
- Women are responsible to pay rent plus \$100 a month for groceries – **due on the 1st of every month.**
- Any medication brought into the house must be stored in blister packs for duration of the program.

Rent amounts are as follows:

Ontario Works (OW):

Single woman: \$384
Mother with an infant: \$632

Ontario Disability Support Program (ODSP):

Single woman: \$489
Mother with an infant: \$769

Responsibilities

As part of communal living, residents are assigned **weekly chores**, have **food preparation/cooking responsibilities** and are expected to follow **curfews**.

The curfews are:

Sunday – Thursday : 11:00 pm

Friday – Saturday: 12:00 am

The curfew for mothers with infants is 8:00 pm daily.



The Jean Tweed Centre Assessment

The Jean Tweed Centre recognizes and values the rich diversity of Canadian society and specifically the communities of women, children and families it serves. We are committed to working from an inclusive, holistic anti-oppression framework to assist women from various cultures, racialized groups, abilities, socio-economic backgrounds, sexual orientation and gender identities with their substance use, mental health and gambling concerns.

First name: _____ Last name: _____ D.O.B.: _____ Age: _____ (dd/mm/yyyy)	
Gender: _____ Last name at birth: _____ Health Card #: _____	
What is your current place of residence? Please check.	
Homeless/on street <input type="checkbox"/>	Shelter/hostel
In rooming/boarded home	Supportive/transitional housing
Private house/apartment	Social/subsidized housing <input type="checkbox"/>
	Couch surfing/staying with friend
	Group home <input type="checkbox"/>
	Treatment facility/hospital/jail <input type="checkbox"/>
Address effect. date: _____ Mailing Address: _____ Apt: _____	
City: _____ Province: _____ Postal Code: _____;	
Home # _____	Okay to: Call – Yes <input type="checkbox"/> No <input type="checkbox"/> Leave Msg. – Yes <input type="checkbox"/> No <input type="checkbox"/> Text msg – Yes <input type="checkbox"/> No <input type="checkbox"/>
Other # _____	Okay to: Call – Yes <input type="checkbox"/> No <input type="checkbox"/> Leave Msg. – Yes <input type="checkbox"/> No <input type="checkbox"/> Text msg – Yes <input type="checkbox"/> No <input type="checkbox"/>
When leaving a voicemail or message with someone, may staff identify themselves as calling from Jean Tweed? Yes No	
Current location if different from above: _____	
Preferred Language: _____ Ethnicity: _____	
Emergency contact : _____ Relation: _____	
Home # _____ Other # _____	
Referring Source Agency Type/Name: _____	
Tel. # _____ Agency Contact: _____	
Presenting Issues: _____ _____ _____	_____ _____ _____
Level of Education Complete: _____ Income Source: _____	
Employment status: _____ Occupation: _____	
Referral Date: _____ Main Client: Yes <input type="checkbox"/> No <input type="checkbox"/> Readmission: Yes <input type="checkbox"/> No <input type="checkbox"/>	

Family physician:

Address:

Telephone:

Number of emergency department visits in the last 12 months:

Reason for emergency department visits:

Number of overnight hospitalizations in the last 12 months (including physical problems):

Reason for most recent hospitalization:

Pregnant:

If yes, due date:

Birth plan:

Diagnosed with a mental health concern by a qualified mental health professional:

Within last 12 months: Yes No

Most Recent Diagnosis #1: _____

Within lifetime: Yes No

Most Recent Diagnosis #2: _____

Details:

Hospitalized due to a mental health concern within last 12 months: Yes No Lifetime: Yes No

Received Counselling/support/treatment for a mental health, emotional, or behavioural concern?

Currently: Yes No Name/ # of service provider: _____

Within last 12 months: Yes No Within Lifetime: Yes No

List all current prescribed medications/vitamins and their purpose(s):

Methadone/Opiode substitute:

Any challenges with: Vision: Hearing: Mobility: 5a_ Wf

****Do you have any allergies, including food allergies? Yes No

Are these allergies life threatening? Yes No (Note: if the allergy is life threatening & if attending the day/residential programming, medical confirmation & recommended treatment (i.e. epi-pen) from a physician is required). Please explain.

Any other health concerns you think we should be aware of? Please describe.

Did you experience difficulty with learning in school? Please describe.

Have you ever been diagnosed with a learning disability? Please describe.

Do you have any concerns with reading and/or writing in English? Please describe.

Have you experienced any of the following over the past 12 months?			
	Yes	No	Please Describe (coping strategies, safety plan/willing to contract, etc.)
Tension/Anxiety/Nervousness			
Depression			
Difficulty Sleeping			
Fears/Phobias			
Feeling that people are against you or trying to harm you?			
Feeling aggressive/violent towards others			
Self-harm behavior			When? How?
Thoughts of suicide			
Suicide attempts			If yes, When?
Financial concerns			When?

Have you experienced any eating concerns (past and/or present) such as anorexia, bulimia, compulsive overeating, laxative abuse, etc.? If yes, how recently?

Legal/Justice Information

Mandated to attend program: Yes No Recommended to attend: Yes No

If yes, by whom:

Do you have any current legal issues? Yes No

If yes, please describe (awaiting trial/hearing/sentence, probation/parole/bail) & dates:

Conditions if any:

Probation/Parole start/end dates: _____ Pending court dates: _____

Sexual Orientation & Gender Identity

Is there anything you would like us to know regarding your sexual orientation or your gender identity that would help us in providing you with high quality care?

Family Social Relationships

If you have children, please list below:

Name	Gender	Age	If your child is under 16 years of age, who has custody?

If your child(ren) are less than 16 yrs old, is child welfare services involved in their care? Yes No
If so, please explain (length of involvement, contact information for worker):

Are you in a relationship at the present time? Yes No If yes, the length of time _____

Past significant relationships: (names are not required)

Yes No

Is or was substance use and/or gambling an issue for anyone in your family?

Does anyone in your family have past/present issues with their mental health? (no names to be recorded)

Do you have support from family/friends/community? Please comment.

Are substances a concern for you? If yes, please complete the following chart:

Substance Use History (If Applicable)

**Note to Referrals: This chart is a supplement to the Admission Discharge DHQ and is required for clients entering the Day/Residential Program **

Primary Substance: _____

Secondary Substance: _____

<i>Substances used that are currently Problematic</i>	<i>Frequency in past 30 days (Did Not Use; 1-3x/mth.; 1-2x/wk.; 3-6x/wk.; Daily; Binge)</i>	<i>Last use date</i>	<i>Approx. length of use (# of Months/ Years)</i>	<i>List all other substances currently being used</i>	<i>Frequency in past 30 days (Did Not Use; 1-3x/mth.; 1-2x/wk.; 3-6x/wk.; Daily; Binge)</i>	<i>Last use date</i>
1.				1.		
2.				2.		
3.				3.		
4.				4.		
5.				5.		

Non-medical injection drug use:	Never		Prior to 1 year		Past 12 months		Unknown	
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Comments:

Is gambling a concern for you? If yes, please complete the following chart:

Gambling History (If Applicable)

(considered a problem, pattern of playing and first and last time played)

	Last 12 months	Problematic		Pattern of playing (ex. Daily)	First Time (age)	Last Time
		Yes	No			
Slot machines						
Gaming machines (other than slots)						
Casino card/table games						
Non-casino card/table games						
Horse races						
Sport betting						
Lottery tickets						
Instant win/scratch tickets						
Internet gambling						
Gambling with stock market/real estate						
Betting on games of skill						
Betting on outcome of events						
Other						
Unknown/data unavailable						

Comments:

For referrals to the Problem Gambling Prog.

(please include completed form with package)

OSAB Gambling Form Completed: Yes No

Do you smoke/use tobacco? Yes No If so, are you interested in making a change? Yes No

What support/services have you accessed for your substance use and/or gambling? (dates, # of times etc.)

What role has substance use and/or gambling played in your life? (positive and/or negative)

Past Experiences

Some women have noticed a connection between their substance and/or gambling use and traumatic experiences (i.e. emotional, physical and sexual abuse, neglect, natural disaster, loss of culture, loss of custody of a child etc...)

Have you had similar experiences that you think are important for us to know about? (description not required)

Are you currently being affected by these experiences? (flashbacks, nightmares, losing time, reactions to sudden noises etc.)? How often?

What do you find helpful in dealing with these effects?

If applicable, are you still in contact with the person(s) who harmed you?

Are you grieving the loss of someone or something? If so please describe:

Any other current stressors/life events that are impacting your substance use or/and gambling?

Please answer these questions if referring to our day/residential programming:

Do you have a place to live upon completion of our day/residential programming? Yes No (Please explain)

Do you have any special dietary requirements?

What are your plans for transportation to/from the Centre? Please note the Centre cannot provide for the cost of transportation.

Preliminary Service Plan

Woman's Perceived Strengths/Coping Skills

1.

2.

3.

Woman's Service Goals

1.

2.

3.

Referrals

1.

2.

3.

Service Plan

1.

2.

3.

Date completed: _____

Completed by: _____

****Please complete for women who are pregnant or parenting children age (0-6) who may be interested in parenting programs at the Jean Tweed Centre.**

Substance Use During Pregnancy			
Are you pregnant right now? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>Current pregnancy</i>			
Substances, frequency, and method of use	1 st Trimester (0-3 months)	2 nd Trimester (3-6 months)	3 rd Trimester (6-10 months)
<i>For each previous pregnancy</i>			
Substances, frequency, and method of use	1 st Trimester (0-3 months)	2 nd Trimester (3-6 months)	3 rd Trimester (6-10 months)
<i>For each previous pregnancy</i>			
Substances, frequency, and method of use	1 st Trimester (0-3 months)	2 nd Trimester (3-6 months)	3 rd Trimester (6-10 months)