The Jean Tweed Centre
For Women & Their Families

The Jean Tweed Centre –Palmerston House Intake Form

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):		**Ontario Disability Support Program (ODSP):**	
Single woman:	$376	Single woman:	$479
Mother with an infant:	$596	Mother with an infant:	$753

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
For Women & Their Families

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 ☐ Shelter/hostel ☐ Couch surfing/staying with friend ☐
In rooming/boarding home ☐ Supportive/transitional housing ☐ Group home ☐
Private house/apartment ☐ Social/subsidized housing ☐ Treatment facility/hospital/jail ☐

Address effect. date:_____ Mailing Address:_____ Apt:_____

City:_____ Province:_____ Postal Code:_____:_____

Home # _____ Okay to: Call – Yes ☐ No ☐ Leave Msg. – Yes ☐ No ☐ Text msg – Yes ☐ No ☐

Other # _____ Okay to: Call – Yes ☐ No ☐ Leave Msg. – Yes ☐ No ☐ Text msg – Yes ☐ No ☐

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 ☐ No ☐ Readmission: Yes ☐ No ☐

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: ☐ Amkkclr

****Do you have any allergies, including food allergies? Yes ☐ q8 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:** _____			
Substances used that are currently Problematic	**Frequency in past 30 days (Did Not Use; 1-3x/mth.; 1-2x/wk.; 3-6x/wk.; Daily; Binge)**	**Last use date**	**Approx. length of use (# of Months/ Years)**	***List all other substances currently being used***	**Frequency in past 30 days (Did Not Use; 1-3x/mth.; 1-2x/wk.; 3-6x/wk.; Daily; Binge)**	**Last use date**
1.				**1.**		
2.				**2.**		
3.				**3.**		
4.				**4.**		
5.				**5.**		
Non-medical injection drug use: Never ☐ Prior to 1 year ☐ Past 12 months ☐ Unknown ☐						

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	First Time (age)	Last Time
		Yes ☐ No ☐	(ex. Daily)		
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 <u>for women who are pregnant or parenting children age (0-6)</u> who may be interested in parenting programs at the Jean Tweed Centre.**

Substance Use During Pregnancy			
Are you pregnant right now? Yes ☐ No ☐			
Current pregnancy			
	1st Trimester (0-3 months)	**2nd Trimester (3-6 months)**	**3rd Trimester (6-10 months)**
Substances, frequency, and method of use			
For each previous pregnancy			
	1st Trimester (0-3 months)	**2nd Trimester (3-6 months)**	**3rd Trimester (6-10 months)**
Substances, frequency, and method of use			
For each previous pregnancy			
	1st Trimester (0-3 months)	**2nd Trimester (3-6 months)**	**3rd Trimester (6-10 months)**
Substances, frequency, and method of use			