The Jean Tweed Centre
JTC
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:	Date of Birth: (dd/mm/yyy)
Gender:	Last Name at Birth:	Health Card #:

What is your current place of residence?

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

Street Address:		Apt.	City:	
Province:	Postal Code:	Address effective date: (dd/mm/yyyy)	Current location if different from above:	
Home Phone #:		Okay to call? Yes No	Okay to leave message? Yes No	Okay to send text msg? Yes No
Other Phone #:		Okay to call? Yes No	Okay to leave message? Yes No	Okay to send text msg? Yes No
When leaving a voicemail or message with someone, may staff identify themselves as calling from Jean Tweed? Yes No				
E-mail address:		Okay to email? Yes No	Note: Privacy and security can not be guaranteed via email. We use e-mail to schedule appointments and we avoid sending sensitive information via e-mail.	

Emergency Contact:	Relation:
Home Phone #:	Other Phone #:

In which of Canada's Official Languages are you most comfortable receiving your healthcare services? English French:	What is your mother tongue? English French Other

Ethnicity Choose an item.	In which language are you most comfortable receiving your healthcare services? * Choose an item.

Level of Education Complete:	Income Source:	Employment Status:	Occupation:

Referring Source Agency Type/Name:	Phone #:	Agency Contact:

Referral Date:	Main Client: Yes No	Readmission: Yes No

Family physician: Does not have a family physician	Address:	Phone #:
Number of emergency department visits in the last 12 months:	Reason for emergency department visit(s):	
Number of overnight hospitalizations in the last 12 months (including for physical problems):	Reason for most recent hospitalization:	

Pregnant: Yes No	If yes, due date:	Birth plan:

Diagnosed with a mental health concern by a qualified mental health professional…	…within the past 12 months? Yes No	…within lifetime? Yes No
Most recent diagnosis #1:		
Most recent diagnosis #2:		
Hospitalized due to a mental health concern…	…within the past 12 months? Yes No	…within lifetime? Yes No
Currently receiving counselling/ support/ treatment for a mental health, emotional, or behavioural concern? Yes No?	If yes, please provide name of service provider:	Phone # of service provider:
Received counselling/ support/ treatment for a mental health, emotional, or behavioural concern…	…within the past 12 months? Yes No	…within lifetime? Yes No

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

Methadone/opioid substitution: Yes No

Any challenges with…	…vision? Yes No	…hearing? Yes No	…mobility? Yes No

****Do you have any allergies, including food and pet allergies? Yes No	If yes, are these allergies life threatening? Yes No If yes, please explain: Note: if these allergies are life threatening, and if attending the day/ residential program, medical confirmation and recommended treatment (i.e., Epi-pen) from a physician is required.

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

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

Have you ever been diagnosed with a learning disability? Yes No	If yes, please describe:

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

Have you ever experienced any of the following in the past 12 month?

Issue	Yes	No	Please describe (e.g., 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 behaviour			When? How?
Thoughts of suicide			
Suicide attempt(s)			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 If yes, by whom?	Recommended to attend? Yes No
Do you current have any legal issues? Yes No	PO/Bail officer contact info:
If yes, please describe (e.g., awaiting trial/ hearing/ sentencing, probation/ parole/ bail) & dates:	
Nature of the Charge(s):	Conditions, if any:
Probation/ Parole start date (dd/mm/yyyy): Probation/ Parole end date (dd/mm/yyyy):	Pending court dates (dd/mm/yyyy):
Have you had past legal involvement ? If yes, nature of the charges:	

Sexual Orientation & Gender Identity

If there anything you would like us to know regarding your sexual orientation and/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 you child is under 16 years of age, who has legal custody?

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

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

Past significant relationship(s)? (names are not required) Yes No Please describe:

Is, or was, substance use and/or gambling an issue for anyone in your family? Yes No Please describe:

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

Do you have significant support from family/ friends/ community/professional? Please List.

Substance Use History (if applicable)

Note to referrals: This chart is a supplement to the Admission Discharge DHQ/GAINQ3 Diagnostics Impressions Report and is required for all 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	Date of last use (dd/mm/yyyy)	Approximate 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	Date of last use (dd/mm/yyyy)
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:

Gambling History

(TO BE COMPLETED FOR ALL CLIENTS, EVEN IF THERE ARE NO CONCERNS WITH GAMBLING)

Is gambling a concern for you? Yes No

Please check all gambling activities in which you engaged in the past 12 months (**regardless of concerns with playing**). Please also indicate, beside the applicable activities, those that are considered a problem, the pattern of playing, age of first time played, and date of last time played.

Type of activity	Played in last 12 months?	If yes, problematic?	Pattern of playing (e.g., daily)	Age first played	Date last played (dd/mm/yyyy)
Slot machines	Yes No	Yes No			
Gaming machines (other than slots)	Yes No	Yes No			
Casino card/ table games	Yes No	Yes No			
Non-casino card/ table games	Yes No	Yes No			
Horse races	Yes No	Yes No			
Sport betting	Yes No	Yes No			
Lottery tickets	Yes No	Yes No			
Instant win/ scratch tickets	Yes No	Yes No			
Internet gambling	Yes No	Yes No			
Gambling with stock market/ real estate	Yes No	Yes No			

Betting on games of skill	Yes No	Yes No			
Betting on outcome of events	Yes No	Yes No			
Other (please specify):	Yes No	Yes No			
Unknown/ data not available	Yes No	Yes No			

Comments:

Have you ever been concerned about your use of technology (such as internet gaming, social media, or online shopping)?
Yes No If yes, please describe:

For referrals to the Problem Gambling Program: (please include completed form with package)	OSAB Gambling Form Completed? Yes No

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

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

What role has substance use and/or gambling played in your life (both positive and 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.)? If so, 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? If so, please describe:

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

Preliminary Service Plan

Strengths:

1.

2.

3.

Coping Skills:

1.

2.

3.

Service Goals & Plans (substance use, mental health, housing, employment, etc.):
1. 2. 3.
Referrals: 1. 2. 3.
Date completed:
Completed by:

To be completed by Jean Tweed Administration	
Presenting Issues:	

*** Please complete this section for women who are pregnant or parenting children aged 0-6 years of age and 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			

Please complete this section for women who are seeking admission to transitional housing programs.

Transitional Program - Personal Goals

- Since completing an intensive program, what supports have you put in place?

- What would you like to accomplish while residing in the transitional program (ex related to substance use, supportive housing, employment, education, child reunification, finances, personal growth, etc.)
    1.
    2.
    3.
- A case manager will work closely with you on your short- and long-term goals. This includes establishing a plan, and regular check-ins. Are you comfortable with this? What kind of support would you like from your case manager?

Transitional Program – Community Living:

- Have you lived in a communal setting with others before? What was it like for you?

- How do you handle conflict? What would you do if you had a disagreement with another resident?

- How do you handle feelings like anger, being upset? What strategies have you been able to successfully use?

- Have you lived independently before? Please describe.