Top of the World Ranch Treatment Centre *Admissions Information Record*			
Demographics			
Client Name:			**Date**:
Date of Birth:	**Health Card #**:		
Gender: Male ☐ Female ☐	**Email Address**:		
Phone #:	**Alt Phone #**:		
May we leave a message? Yes ☐ No ☐	**Is there a best time of day to reach you?** Yes ☐ No ☐ If "Yes," when?		
Street Address:			**City**:
Mailing Address:			
Province:	**Postal Code**:		**Country**:
Relationship/Dependents			
Marital Status:	**Dependents**: Yes ☐ No ☐ **Names & Ages**:		**Do children reside with you?** Yes ☐ No ☐
Emergency Contact Information			
Emergency Contact: **Relationship to Client**:			**Phone #**:
Mailing Address:			**City**:
Province:		**Postal Code**:	**Country**:
Email Address:			
Personal Information			
Height:	**Weight**:		**Eye Colour**:
Hair Colour:	**Tattoos**:		**Religious/Spiritual Affiliation**:
Identifying Features:			
Current Employment (include company and position): **If treatment will impact your employment, please explain**:			

Referral Source

Please check one of the following referral source boxes:
Self-Referral ☐ Family Member ☐ Counsellor ☐ Doctor ☐ Employer ☐ Alumni ☐ Other ☐

Name of Referring Individual:	**Phone #**:

Contact information for referral source:

Legal History

History of Violence: Yes ☐No☐	**Pending Court Date**: Yes☐No☐ If "Yes," when?	**Outstanding Warrants**: Yes ☐No☐
Probation: Yes ☐ No ☐	**Parole**: Yes ☐ No ☐	**Other legal**: Yes ☐ No ☐

If "Yes" to any of the above, please explain in detail (please include any potential court involvement that might impact your stay in treatment):

Substance Use History

Alcohol

Ever Used? Yes ☐ No ☐	**Date First Use**	**Frequency**	**Tried to stop?** Yes ☐ No ☐	**Duration of Sobriety**	**Date Last Use**	**Quantity**	**History of Withdrawal Seizures?** Yes ☐ No ☐

What type of alcohol do you consume? (e.g., Vodka, Wine, Beer etc.)

Have you ever consumed non-beverage alcohol, such as hand sanitizer, antifreeze, eau-du-cologne? Yes ☐ No ☐

If "Yes," please describe what, how often, first and last use.

What are your drinking habits or patterns (e.g., daily, weekends)?

In the past when you tried to stop drinking, what happened?

Please describe what your withdrawal was like.

Did you experience any of the following withdrawal symptoms?
☐ Dehydration ☐ Sweats ☐ Anxiety ☐ Fear ☐ Seizures ☐ Hallucinations ☐ Delirium Tremens
☐ Pneumonia
If "Yes" to any of the above, please describe:

Marijuana/Hash/ Shatter, etc. (Include medical marijuana) Please specify:

Ever Used Yes ☐ No ☐	Date First Use	Frequency	Tried to stop? Yes ☐ No ☐	Duration of no use	Date Last Use	Quantity	Route of Administration (How used?)

Opioids (Heroin, Morphine, Dilaudid, Oxy's, Fentanyl etc.). Please specify:

Ever Used Yes ☐ No ☐	Date First Use	Frequency	Tried to stop? Yes ☐ No ☐	Duration of no use	Date Last Use	Quantity	Route of Administration (How used?)

Is the client presently on any opiate replacement therapy (ORT)?
Yes ☐ No ☐

If "Yes," which therapy? ☐ *Methadone* ☐ *Suboxone* **How long**? _____

Current Dosage: _____ **Impact on Alertness**: _____

Name of Clinic/Prescribing Physician: _____

Phone: _____ **Fax**: _____

If you are not already on opiate replacement therapy (ORT), do you wish to use an opiate replacement therapy*?*
Yes ☐ No ☐

I have been informed of and agree to schedule an aftercare appointment for ORT while in treatment here?
Yes ☐ No ☐

If I have been using opiates prior to coming to treatment (usually within past month), I am aware that I will be admitted to detox for a period of assessment?
Yes ☐ No ☐

If you are on an opioid other than ORT our policy and practice is to taper clients off of opioids. Are you willing to work with the Ranch doctor to taper off of any opioids? Yes ☐ No ☐

Amphetamines (e.g., Crystal Meth, Dexedrine, Adderall). Please specify:

Ever Used Yes ☐ No ☐	First Use	Frequency	Tried to stop? Yes ☐ No ☐	Duration of no use?	Last Use	How Much?	Route of Administration (How used?)

Were any amphetamines prescribed to you by a physician? Yes ☐ No ☐

If "Yes," list the prescribing physician:

Contact information (including phone number):

Have you ever misused or abused these medications (amphetamines) as prescribed? Yes ☐ No ☐
If "Yes," please explain:

Cocaine/Crack. Please specify:

Ever Used Yes ☐ No ☐	**Date First Use**	**Frequency**	**Tried to stop?** Yes ☐ No ☐	**Duration of no use?**	**Date Last Use**	**Quantity**	**Route of Administration (How used?)**

Hallucinogens (e.g., Mushrooms, LSD, Salvia,). Please specify:

Ever Used Yes ☐ No ☐	**Date First Use**	**Frequency**	**Tried to stop?** Yes ☐ No ☐	**Duration of no use?**	**Date Last Use?**	**Quantity**	**Route of Administration (How used?)**

Club Drugs (e.g., Ecstasy, Ketamine, GHB). Please specify:

Ever Used Yes ☐ No ☐	**Date First Use**	**Frequency**	**Tried to stop?** Yes ☐ No ☐	**Duration of no use?**	**Date Last Use?**	**Quantity**	**Route of Administration (How used?)**

Benzodiazepines (e.g., Valium, Ativan, Xanax, Clonazepam). Please specify:

Ever Used Yes ☐ No ☐	**Date First Use**	**Frequency**	**Tried to stop?** Yes ☐ No ☐	**Duration of no use?**	**Date Last Use?**	**Quantity**	**Route of Administration (How used?)**

Were these medications (benzodiazepines) prescribed to you? Yes ☐ No ☐

If "Yes," list the prescribing physician:

Contact information (including phone number):

Have you ever misused or abused these medications (benzodiazepines) as prescribed? **In other words, have you taken them in a way that was not prescribed?**
Yes ☐ No ☐
If "Yes," please explain:

How long have you been taking these medications (benzodiazepines)?

If you are on benzodiazepines our policy and practice is to taper clients off of benzodiazepines. Are you willing to work with the Ranch doctor to taper off of any benzodiazepines? Yes ☐ No ☐

Tobacco (e.g., cigarettes, chewing tobacco). Please specify:

Ever Used Yes ☐ No ☐	**First Use**	**Frequency**	**Tried to stop?** Yes ☐ No ☐	**Duration of no use?**	**Last Use?**	**How Many per day?**	**Would you like to stop?** Yes ☐ No ☐

Other Addictive Behaviors:

Shopping Yes ☐ No ☐ **Gambling** Yes ☐ No ☐
Sex/Pornography Yes ☐ No ☐ **Excessive Work** Yes ☐ No ☐
Love/Relationships Yes ☐ No ☐ **Excessive Exercise** Yes ☐ No ☐ **Emotional Eating** Yes ☐ No ☐ **Gaming** Yes ☐ No ☐

Do you or others see any of these behaviors as negatively impacting your life, such as relationships or work? Yes ☐ No ☐

If "Yes" to Other Addictive Behavior(s), please provide examples:

Health Assessment

Are you Diabetic? Yes ☐ No ☐ **Type 1 ☐ Type 2 ☐**
Insulin Dependent? Yes ☐ No ☐ **Medication?** Yes ☐ No☐

If "Yes," is your Diabetes well and consistently managed? Yes ☐ No☐

Gastrointestinal Issues: Yes ☐ No ☐	**Celiac Disease:** Yes ☐ No ☐
Hypo/Hyper Glycemic: (please circle) Yes ☐ No ☐	**Crohn's Disease:** Yes ☐ No ☐
Potentially Pregnant: Yes ☐ No ☐	**Colitis** Yes: ☐ No ☐
Pancreatitis: Yes ☐ No ☐	**Irritable Bowel Syndrome (IBS): Yes ☐ No ☐**
Migraines: Yes ☐ No ☐	**Liver Failure or low function:** Yes ☐ No ☐
Cirrhosis Yes: ☐ No ☐	**Hep B / Hep C: (please circle)**
HIV/AIDS Yes: ☐ No ☐	**Heart Failure/ Heart Condition:** Yes ☐ No ☐
Acquired Brain Injury: Yes ☐ No ☐ If "Yes," did this involve a loss of consciousness? Yes ☐ No ☐	**Kidney Issues:** Yes ☐ No ☐
Chronic Pain: Yes ☐ No ☐	**Mobility Issues:** Yes ☐ No ☐
Learning Disability Yes ☐ No ☐	**Injuries/ Accidents** Yes ☐ No ☐
Epilepsy/ Seizure Disorder Yes ☐ No ☐	**Have you ever been diagnosed with insomnia or other sleep disorder, such as sleep apnea?**

	Yes ☐ No ☐
If "Yes" to any of the above Health Assessment questions, please explain:	
Are you currently having suicidal thoughts? Yes ☐ No ☐ **Have you in the past 3 months?** Yes ☐ No ☐ **Have you ever had suicidal thoughts?** Yes ☐ No ☐	
Have you ever attempted Suicide? Yes ☐ No ☐ **Have you attempted Suicide in the past 3 months?** Yes ☐ No ☐ **Did you require any medical attention, such as an Emergency Room Hospital visit?** Yes ☐ No ☐	
Do you currently engage in self-harm behavior? Yes ☐ No ☐ **Have you engaged in self-harm in the past 3 months?** Yes ☐ No ☐ **Were you using alcohol or drugs at the time of the self-harm?** Yes ☐ No ☐ **Did you require any medical attention, such as an Emergency Hospital visit?** Yes ☐ No ☐	
Please give us any further details to any of the above situations, such as when, how many times, etc.:	

Medications, Vitamins and Supplements (All Prescribed and Over the Counter) ***Please give a detailed list of your current medications***					
Medication Name	Dosage (mg)	How often?	Time of Day Taken	Is it PRN (as needed)?	Why do you take this medication?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Please read the following: Clients are asked to arrive at the ranch WITH CURRENT, VALID, PRESCRIPTIONS FROM THEIR PHYSICIAN with refills available for at least 30 days. Alternatively, prescriptions held at a client's home pharmacy, can be transferred electronically to the Top of the World Ranch's pharmacy upon request. If a client arrives to the Ranch with neither of these options for prescription medications, a renewal will need to be discussed at a visit with our Ranch Physician. **I have read and understand and agree to the above.** Yes ☐ No ☐ ***If you require further explanation of the above, please do not hesitate to ask Ranch staff prior to attending treatment.***
Please read the following: "For safety reasons, all over the counter medications or herbal supplements must be approved for use by our Ranch Physician. Please limit all supplements to those that you feel are NEEDED rather than DESIRED. Unless there is a medically necessary reason stated by a licensed physician, we will limit the number of herbal supplements to 4 (four). We will require a medical note." **I have read and understand the above requirement.** Yes ☐ No ☐

Pharmacy:	**Phone #:**
Pharmacy Location:	

Allergies/ Dietary		
Food Allergies? Yes ☐ No ☐	**Drug Allergies?** Yes ☐ No ☐	**Any Other Allergies?** Yes ☐ No ☐
If "Yes" to any of the above, please explain in detail, including any serious reactions that you have had in the past to these allergies:		
Please describe any Dietary Restrictions we should know about? (i.e., Vegetarian/Vegan/Lactose Intolerant/ Sodium Controlled Diet):		
Please describe any dietary Religious Restrictions we should be aware of:		

TB Screening	
Chronic Cough (+ 2 weeks) Yes ☐ No ☐	**First Nations AND on Reserve** Yes ☐ No ☐
Productive Cough (mucus/phlegm) Yes ☐ No ☐	**Recent or Past Exposure to TB (Circle one)**
Bloody Sputum (hemoptysis) Yes ☐ No ☐	**Previous Active TB with Treatment** Yes ☐ No ☐
Rapid Weight Loss Yes ☐ No ☐	**Positive Mantoux Test / CXR** Yes ☐ No ☐
Night Sweats Yes ☐ No ☐	**History of Birth/ Travel to Countries with high incidence of TB** Yes ☐ No ☐
Fever (often low grade) Yes ☐ No ☐	**History of Correctional Institution or Long-Term Care Facility** Yes ☐ No ☐
Feelings of Fatigue Yes ☐ No ☐	**History of Intravenous Drug Use/ IV Substance Use** Yes ☐ No ☐

Immunization History	
To the best of your knowledge, are you:	
Fully Immunized Yes ☐ No ☐	**Have you ever had an adverse reaction to a vaccine?** Yes ☐ No ☐
Immunized as a child Yes ☐ No ☐	**If Yes to adverse reaction, please explain:**
Immunized through work Yes ☐ No ☐	**Immunized for travel** Yes ☐ No ☐
Did you receive the Flu vaccine this year? Yes ☐ No ☐	**Are you interested in receiving the Flu vaccine?** Yes ☐ No ☐
Intensive Residential Treatment Readiness	
Have you ever been formally diagnosed by a mental health professional with a Mental Health Disorder or Concurrent Disorders? Yes ☐ No ☐ **If "Yes," please list your diagnosis and approximate date of diagnosis:**	**Do you have any concerns about:** Feeling depressed, sad, lacking energy or lacking enjoyment in life? Yes ☐ No ☐ Feeling nervous, anxious or agitated? Yes ☐ No ☐ Quality of, or amount of sleep? Yes ☐ No ☐
Anorexia: Yes ☐ No ☐ Current/Past (Please circle) If Yes, is this only present while you are actively using? Yes ☐ No ☐	**Bulimia:** Yes ☐ No ☐ Current/Past (Please circle) If Yes, is this only present while you are actively using? Yes ☐ No ☐
Any binge or purge eating behaviors that do not meet criteria for an Eating Disorder? Yes ☐ No ☐	**Have you ever been exposed to a natural disaster, such as a hurricane, flooding, fire, or an earthquake?** Yes ☐ No ☐
Do you have history of physical abuse or trauma? Yes ☐ No ☐	**Do you have history of sexual abuse or trauma?** Yes ☐ No ☐
Do you have a history of having been exposed to domestic violence? Yes ☐ No ☐	**Have you been the victim of or witnessed a violent crime?** Yes ☐ No ☐
Did you grow up in a neighborhood that was characterized by violence or criminal behavior? Yes ☐ No ☐	**Have you been the victim of bullying (including cyber bullying) or threatening behavior?** Yes ☐ No ☐
Counselling History	
Have you received counseling, psychological or psychiatric services in the past? Yes ☐ No ☐	
How long ago?	**For how long?**
What were your goals while you attended and what was most helpful?	
May we contact these Providers? Yes ☐ No ☐ **(Note: this requires a separate Release of Information to be completed).**	
If "Yes," please provide name and contact information, including phone number for counsellor or psychiatrist:	

Previous Substance Abuse Treatment Experience	
Have you previously attended a Substance Abuse Treatment Centre? Yes ☐ No ☐	**If "Yes," was it:** Outpatient ☐ Residential ☐
May we contact these Providers? Yes ☐ No ☐ **(Note: this requires a separate Release of Information to be completed).**	
Did you complete the program? Yes ☐ No ☐ If "No," please explain.	**Date(s):**
Name of Treatment Program(s): **Contact Information (including phone number):**	
What were your goals while you attended and what was most helpful?	
Client Readiness to Change Questions	
What are your personal goals for treatment here at the Ranch? What changes do you want to make in your life?	
On a scale of 1 to 10 (1 being *not at all* and 10 being *extremely*), how important is it to you that you make these changes?	
On a scale of 1 to 10 (1 being *not at all* and 10 being *extremely*), how confident are you that you can make these changes?	
What do you feel may be challenges during your stay at treatment?	
How can we work with you to minimize these challenges?	
Describe any previous involvement with self-support groups (ex: NA, AA, ACOA, etc.):	