

Top of the World Ranch Treatment Centre Admissions Information Record		
Demographics		
Client Name:		Date:
Date of Birth:	Health Card #:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Email Address:	
Phone #:	Alt Phone #:	
May we leave a message? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is there a best time of day to reach you? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," when?	
Street Address:		City:
Mailing Address:		
Province:	Postal Code:	Country:
Relationship/Dependents		
Marital Status:	Dependents: Yes <input type="checkbox"/> No <input type="checkbox"/>	Do children reside with you? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Names & Ages:	
Emergency Contact Information		
Emergency Contact:		Phone #:
Relationship to Client:		
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 <input type="checkbox"/> Family Member <input type="checkbox"/> Counsellor <input type="checkbox"/> Doctor <input type="checkbox"/> Employer <input type="checkbox"/> Alumni <input type="checkbox"/> Other <input type="checkbox"/>							
Name of Referring Individual:						Phone #:	
Contact information for referral source:							
Name of Person Completing the Application:							
Physician Information							
Name of Family Practice/General Practice Physician:							
Address:				Phone Number:			
Legal History							
History of Violence: Yes <input type="checkbox"/> No <input type="checkbox"/>		Pending Court Date: Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," when?			Outstanding Warrants: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Probation: Yes <input type="checkbox"/> No <input type="checkbox"/>		Parole: Yes <input type="checkbox"/> No <input type="checkbox"/>			Other legal: Yes <input type="checkbox"/> No <input type="checkbox"/>		
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?	Date First Use	Frequency	Tried to stop?	Duration of Sobriety	Date Last Use	Quantity	History of Withdrawal Seizures?
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/> 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	Date First Use	Frequency	Tried to stop?	Duration of no use	Date Last Use	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

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

Ever Used	Date First Use	Frequency	Tried to stop?	Duration of no use	Date Last Use	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

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	First Use	Frequency	Tried to stop?	Duration of no use?	Last Use	How Much?	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				
<p>Were any amphetamines prescribed to you by a physician? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes," list the prescribing physician:</p> <p>Contact information (including phone number):</p>							
<p>Have you ever misused or abused these medications (amphetamines) as prescribed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes," please explain:</p>							
Cocaine/Crack. Please specify:							
Ever Used	Date First Use	Frequency	Tried to stop?	Duration of no use?	Date Last Use	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				
Hallucinogens (e.g., Mushrooms, LSD, Salvia,). Please specify:							
Ever Used	Date First Use	Frequency	Tried to stop?	Duration of no use?	Date Last Use?	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				
Club Drugs (e.g., Ecstasy, Ketamine, GHB). Please specify:							
Ever Used	Date First Use	Frequency	Tried to stop?	Duration of no use?	Date Last Use?	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				
Benzodiazepines (e.g., Valium, Ativan, Xanax, Clonazepam). Please specify:							
Ever Used	Date First Use	Frequency	Tried to stop?	Duration of no use?	Date Last Use?	Quantity	Route of Administration (How used?)
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>				

<p>Were these medications (benzodiazepines) prescribed to you? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes," list the prescribing physician:</p> <p>Contact information (including phone number):</p>							
<p>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?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes," please explain:</p>							
<p>How long have you been taking these medications (benzodiazepines)?</p> <p>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 <input type="checkbox"/> No <input type="checkbox"/></p>							
<p>Tobacco (e.g., cigarettes, chewing tobacco). Please specify:</p>							
<p>Ever Used</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>First Use</p>	<p>Frequency</p>	<p>Tried to stop?</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>Duration of no use?</p>	<p>Last Use?</p>	<p>How Many per day?</p>	<p>Would you like to stop? Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
<p>Other Addictive Behaviors:</p> <p>Shopping Yes <input type="checkbox"/> No <input type="checkbox"/> Gambling Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Sex/Pornography Yes <input type="checkbox"/> No <input type="checkbox"/> Excessive Work Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Love/Relationships Yes <input type="checkbox"/> No <input type="checkbox"/> Excessive Exercise Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Emotional Eating Yes <input type="checkbox"/> No <input type="checkbox"/> Gaming Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you or others see any of these behaviors as negatively impacting your life, such as relationships or work? Yes <input type="checkbox"/> No <input type="checkbox"/></p>						<p>If "Yes" to Other Addictive Behavior(s), please provide examples:</p>	

Health Assessment	
<p>Are you Diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Insulin Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes," is your Diabetes well and consistently managed? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/></p> <p>Medication? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Gastrointestinal Issues: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Hypo/Hyper Glycemic: (please circle) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Potentially Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Pancreatitis: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Migraines: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Cirrhosis: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>HIV/AIDS: Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Celiac Disease: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Crohn's Disease: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Colitis: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Irritable Bowel Syndrome (IBS): Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Liver Failure or low function: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Hep B / Hep C: (please circle)</p> <p>Heart Failure/ Heart Condition: Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Acquired Brain Injury: Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," did this involve a loss of consciousness? Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Issues: Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Pain: Yes <input type="checkbox"/> No <input type="checkbox"/>	Mobility Issues: Yes <input type="checkbox"/> No <input type="checkbox"/>
Learning Disability Yes <input type="checkbox"/> No <input type="checkbox"/>	Injuries/ Accidents Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy/ Seizure Disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever been diagnosed with insomnia or other sleep disorder, such as sleep apnea? Yes <input type="checkbox"/> No <input type="checkbox"/>
If "Yes" to any of the above Health Assessment questions, please explain:	
Are you currently having suicidal thoughts? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you in the past 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you ever had suicidal thoughts? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you ever attempted Suicide? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you attempted Suicide in the past 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you require any medical attention, such as an Emergency Room Hospital visit? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you currently engage in self-harm behavior? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you engaged in self-harm in the past 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/> Were you using alcohol or drugs at the time of the self-harm? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you require any medical attention, such as an Emergency Hospital visit? Yes <input type="checkbox"/> No <input type="checkbox"/>	
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)					
<i>Please give a detailed list of your current medications</i>					
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.					
<p>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.</p> <p>I have read and understand and agree to the above. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>If you require further explanation of the above, please do not hesitate to ask Ranch staff prior to attending treatment.</i></p>					
<p>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."</p> <p>I have read and understand the above requirement. Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
Pharmacy:			Phone #:		
Pharmacy Location:					

Allergies/ Dietary		
Food Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>	Any Other Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	First Nations AND on Reserve Yes <input type="checkbox"/> No <input type="checkbox"/>	
Productive Cough (mucus/phlegm) Yes <input type="checkbox"/> No <input type="checkbox"/>	Recent or Past Exposure to TB (Circle one)	
Bloody Sputum (hemoptysis) Yes <input type="checkbox"/> No <input type="checkbox"/>	Previous Active TB with Treatment Yes <input type="checkbox"/> No <input type="checkbox"/>	
Rapid Weight Loss Yes <input type="checkbox"/> No <input type="checkbox"/>	Positive Mantoux Test / CXR Yes <input type="checkbox"/> No <input type="checkbox"/>	

Night Sweats Yes <input type="checkbox"/> No <input type="checkbox"/>	History of Birth/ Travel to Countries with high incidence of TB Yes <input type="checkbox"/> No <input type="checkbox"/>
Fever (often low grade) Yes <input type="checkbox"/> No <input type="checkbox"/>	History of Correctional Institution or Long-Term Care Facility Yes <input type="checkbox"/> No <input type="checkbox"/>
Feelings of Fatigue Yes <input type="checkbox"/> No <input type="checkbox"/>	History of Intravenous Drug Use/ IV Substance Use Yes <input type="checkbox"/> No <input type="checkbox"/>
Immunization History	
To the best of your knowledge, are you:	
Fully Immunized Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had an adverse reaction to a vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/>
Immunized as a child Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes to adverse reaction, please explain:
Immunized through work Yes <input type="checkbox"/> No <input type="checkbox"/>	Immunized for travel Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you receive the Flu vaccine this year? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you interested in receiving the Flu vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/>
Intensive Residential Treatment Readiness	
Have you ever been formally diagnosed by a mental health professional with a Mental Health Disorder or Concurrent Disorders? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Feeling nervous, anxious or agitated? Yes <input type="checkbox"/> No <input type="checkbox"/> Quality of, or amount of sleep? Yes <input type="checkbox"/> No <input type="checkbox"/>
Anorexia: Yes <input type="checkbox"/> No <input type="checkbox"/> Current/Past (Please circle) If Yes, is this only present while you are actively using? Yes <input type="checkbox"/> No <input type="checkbox"/>	Bulimia: Yes <input type="checkbox"/> No <input type="checkbox"/> Current/Past (Please circle) If Yes, is this only present while you are actively using? Yes <input type="checkbox"/> No <input type="checkbox"/>
Any binge or purge eating behaviors that do not meet criteria for an Eating Disorder? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever been exposed to a natural disaster, such as a hurricane, flooding, fire, or an earthquake? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have history of physical abuse or trauma? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have history of sexual abuse or trauma? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a history of having been exposed to domestic violence? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you been the victim of or witnessed a violent crime? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you grow up in a neighborhood that was characterized by violence or criminal behavior? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you been the victim of bullying (including cyber bullying) or threatening behavior? Yes <input type="checkbox"/> No <input type="checkbox"/>
Counselling History	
Have you received counseling, psychological or psychiatric services in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>	
How long ago?	For how long?
What were your goals while you attended and what was most helpful?	

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

For Staff Use Only	
Client Name:	Date:
Date of Birth:	Health Card #:
Phone #:	Alt Phone #:
Staff member Completing AIR (print name):	Initials:
Is this client Approved? Yes <input type="checkbox"/> No <input type="checkbox"/>	Approved by:
Further questions required regarding medical: Yes <input type="checkbox"/> No <input type="checkbox"/>	Contacted by:
Client has been informed of their approval to the Program: <input type="checkbox"/> Initials:	
Client has been informed about the non-refundable \$4000.00 deposit to secure their bed at TOWR: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Client has been informed about the drug screening policy understand that if they test positive for an undeclared substance or are intoxicated at the time of arrival, they will be taken to the Detox for a minimum of 72 hours. <input type="checkbox"/>	
Client has been informed of and agrees to the requirement of having tapering off of any opioids and/or benzodiazepines? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Regarding Prescription Medications: The client has acknowledged reading the requirements, has been asked if they have any questions, and their questions have been answered. They have consented to these requirements. Yes <input type="checkbox"/> No <input type="checkbox"/>	
Regarding TB screen items, if "YES" was answered to any of the above, please correspond with the Ranch Nurse prior to approval. This has been done. Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Client has been informed about required AA/NA, self-support groups 4 times per week while attending the Ranch. <input type="checkbox"/>	
If client is 25 or younger , they have been informed of the required attendance in the Family Intensive Program and have agreed to participate. Yes <input type="checkbox"/> No <input type="checkbox"/> They understand and agree to a residential stay of at least 45 days ? Yes <input type="checkbox"/> No <input type="checkbox"/> They understand and agree that they will be admitted to detox for a period of 72 hrs. for a medical and biopsychosocial assessment of treatment readiness? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Financial Information	
Funding Provider:	The Agreement of Payment for Residential Treatment form has been completed by (please print):
Relationship:	Phone:
Length of Stay: <input type="checkbox"/> Undecided <input type="checkbox"/> 90 days <input type="checkbox"/> 60 Days <input type="checkbox"/> 45 Days <input type="checkbox"/> 30 Days	Email:
Is Detox required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Additional Notes:	