

Support. Hope. Thrive.

**INSTRUCTIONS:**

1. Complete and print form or fill out by hand.
2. The form must be faxed or mailed to Stonehenge. Please note, emailed applications will not be accepted. For in person assessments you may bring the completed form on the day of your appointment and do not need to send it ahead of time.
3. You must call the Stonehenge Office Coordinator to book your intake assessment 519-837-1470 x 221.

**MAILING ADDRESS:**

Stonehenge Therapeutic  
Community  
C/O Admissions  
60 Westwood Road  
Guelph, ON N1H 7X3

**FAX NUMBER: 519- 837-3232**

Completed applications can be faxed to  
Please mark with 'Attention: Admissions'.  
**WEBSITE:** Detailed information on our  
programs and the assessment process  
can be found at [www.stonehengeetc.com](http://www.stonehengeetc.com)

**PHONE NUMBER: 519-837-1470**

ADMISSIONS COORDINATORS EXTENTIONS:  
Women's Program x226  
Men's Health and Provincial Program x227  
Men's Federal Program x232  
Office Coordinator x221

**FOR OFFICE USE ONLY** Referred On:

Status:  Health  Provincial Corrections  Federal Corrections  Fee-for-Service

**START APPLICATION HERE**

**PERSONAL INFORMATION**

First Name:		Last Name:	
Full name at birth (if different than above):			
If you use an alternative name, please include it:			
Date of Birth:		Gender:	Pronouns:
Do you have an Ontario Health Card? <input type="checkbox"/> Yes <input type="checkbox"/> No		Health Card Number:	
Home Address:		City:	Province:
Postal Code:	Do you have a fixed address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Phone Number:		Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact:		Relationship:	
Emergency Contact Phone #:		Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language you prefer to receive service in?			
Ethnicity (e.g. Canadian, First Nations, Irish, etc.):			Birth Place:

**REFERRAL INFORMATION**

Please specify the referring agency(ies):		
Contact name at referring agency(ies):		
Please check the boxes that explain who referred you to Stonehenge:		
<input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Initial Assessment Treatment Planning <input type="checkbox"/> Withdrawal Management Centre <input type="checkbox"/> Community Withdrawal Management <input type="checkbox"/> Residential Addiction Treatment <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Outpatient Addiction Services	<input type="checkbox"/> Day/Evening Addiction Services <input type="checkbox"/> Psychiatric Services <input type="checkbox"/> Psychiatrist/Psychologist <input type="checkbox"/> Medical Services <input type="checkbox"/> Community Health Centre <input type="checkbox"/> Physician/Private Practice <input type="checkbox"/> Public Health Unit Nurse <input type="checkbox"/> Community Mental Health	<input type="checkbox"/> Correctional Facility <input type="checkbox"/> Non-Addictions Residential <input type="checkbox"/> Self-Help Group <input type="checkbox"/> EAP/Employer <input type="checkbox"/> Police <input type="checkbox"/> Other Legal <input type="checkbox"/> Connex Website <input type="checkbox"/> Other

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EMPLOYMENT STATUS:					
<input type="checkbox"/> (Self) Employed Full-time	<input type="checkbox"/> Student/Re-training	<input type="checkbox"/> Not in Labour Force (e.g. homemaker)			
<input type="checkbox"/> Employed Part-time	<input type="checkbox"/> Disability	<input type="checkbox"/> Retired			
<input type="checkbox"/> Unemployed (looking for work)					
EDUCATION: (HIGHEST LEVEL ACHIEVED):					
<input type="checkbox"/> No formal schooling	<input type="checkbox"/> Some Secondary or High School	<input type="checkbox"/> Completed College/CEGEP/Nursing			
<input type="checkbox"/> Some Primary School	<input type="checkbox"/> Completed Secondary or High School	<input type="checkbox"/> Some University			
<input type="checkbox"/> Completed primary School	<input type="checkbox"/> Some College/CEGEP/Nursing	<input type="checkbox"/> Completed University Degree/Masters/PhD			
INCOME SOURCE:					
<input type="checkbox"/> Disability Insurance	<input type="checkbox"/> None	<input type="checkbox"/> Other Insurance (excluding E.I.)			
<input type="checkbox"/> Employment	<input type="checkbox"/> Ontario Disability (ODSP)	<input type="checkbox"/> Retirement Income			
<input type="checkbox"/> Employment Insurance (E.I.)	<input type="checkbox"/> Ontario Works (OW)	<input type="checkbox"/> Other			
<input type="checkbox"/> Family Support					
PREVIOUS TREATMENT INFORMATION					
Have you had previous substance use treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, complete chart below)					
Treatment Facility/Location	Type of Treatment	Date Attended (mm/yyyy)	Program Length	Completed?	
				<input type="checkbox"/> No	<input type="checkbox"/> Yes
				<input type="checkbox"/> No	<input type="checkbox"/> Yes
				<input type="checkbox"/> No	<input type="checkbox"/> Yes
				<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had previous treatment at Stonehenge? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when:					
IDENTIFIED FAMILY					
Please identify your current relationship status:					
<input type="checkbox"/> Married <input type="checkbox"/> Partnered/Common Law <input type="checkbox"/> Single (never married) <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widow/Widower					
Please identify your immediate family members in the chart below:					
Family Member Name	Relationship	Age	Do you have contact with them?	Are they supportive of Treatment?	Do they have problematic substance use?



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PHYSICAL HEALTH STATUS	
Family Doctor (if applicable):	Phone Number:
Please check any health issues that apply to you:	
<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Mobility concerns
<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Communicable diseases (e.g. Hepatitis, HIV)	<input type="checkbox"/> Acquired Brain Injury
Please describe your physical health concerns:	
Please list any allergies:	
Please list any dietary requirements:	
Please indicate the number of <u>overnight hospitalizations</u> in the <u>last 12 months</u> for <u>physical problems</u> :	
Please indicate the number of <u>Emergency Department</u> visits in the <u>last 12 months</u> for <u>any issue</u> :	
Reason for most recent hospitalization:	
Have you been diagnosed with a developmental or learning disability? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain below)	
MENTAL HEALTH STATUS	
Have you received a mental health diagnosis by a mental health professional?	
Within the last 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes      Within your lifetime? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, please explain:	
Have you been <u>hospitalized</u> for a mental health concern within the last 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you been <u>hospitalized</u> for a mental health concern within your lifetime? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you received <u>treatment</u> for a mental health, emotional, behavioural or psychological concern from a professional?	
Currently <input type="checkbox"/> No <input type="checkbox"/> Yes      Within the last 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes      Within your lifetime? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Name of service provider:	Phone Number:
Do you engage in any self-harm behaviours (e.g. cutting)? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, what?):	
Have you ever attempted suicide? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, when?):	
Have you ever overdosed? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, when?):	
Have you ever injected drugs for non-medical use?	
<input type="checkbox"/> Never injected <input type="checkbox"/> Injected within the past year <input type="checkbox"/> Injected over a year ago	
Do you currently struggle with an eating disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes	
In the past, have you struggled with an eating disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes	

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MEDICATIONS				
Please list <u>all</u> your current medication(s):			Please indicate your current dosage(s):	
1.				
2.				
3.				
4.				
5.				
Have you been prescribed medication for mental health concerns?				
Currently <input type="checkbox"/> No <input type="checkbox"/> Yes      Within the last 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes      Within your lifetime? <input type="checkbox"/> No <input type="checkbox"/> Yes				
OPIOID SUBSTITUTION				
Are you currently participating in an opioid substitution program? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please indicate below)				
<input type="checkbox"/> Methadone <input type="checkbox"/> Suboxone <input type="checkbox"/> Sublocade				
If yes, who is your prescriber?				
What is your current dosage?				
SUBSTANCE USE HISTORY				
What are your current drugs of choice? Please list in order of severity. During <u>active substance use</u> , how frequently would you use each substance?				
Drug of Choice	Frequency in <u>Active</u> Substance Use		Method of Use	
1.	<input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly <input type="checkbox"/> 3-6 times weekly	<input type="checkbox"/> Daily <input type="checkbox"/> Binge	<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
2.	<input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly <input type="checkbox"/> 3-6 times weekly	<input type="checkbox"/> Daily <input type="checkbox"/> Binge	<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
3.	<input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly <input type="checkbox"/> 3-6 times weekly	<input type="checkbox"/> Daily <input type="checkbox"/> Binge	<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
4.	<input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly <input type="checkbox"/> 3-6 times weekly	<input type="checkbox"/> Daily <input type="checkbox"/> Binge	<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
5.	<input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly <input type="checkbox"/> 3-6 times weekly	<input type="checkbox"/> Daily <input type="checkbox"/> Binge	<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
How old were you when you first tried your current drug of choice?				
How old were you when you first tried any drugs or alcohol?				

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SUBSTANCE USE HISTORY continued			
Please indicate any substances used in the <u>past 12 months</u> (select all that apply)			
Substance	Date Used	Method of Use	
<input type="checkbox"/> Alcohol		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Amphetamines and other stimulants		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Barbiturates		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Benzodiazepines		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Cannabis		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Cocaine		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Crack		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Ecstasy/MDMA		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Glue/Inhalants		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Hallucinogens		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Heroin/Opium		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Methamphetamines (e.g. crystal meth)		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Other psychoactive substances		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Over-the-counter Codeine		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Prescription Opioids		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Steroids		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Tobacco		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Other (please specify)		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed

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<b>GAMBLING</b>	
Have you ever had gambling identified as a problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you be interested in treatment for gambling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate below any gambling activities engaged in the past <u>12 months</u> :	
<input type="checkbox"/> Bingo <input type="checkbox"/> Slot machines <input type="checkbox"/> Gambling machines (other than slots) <input type="checkbox"/> Casino card or table games <input type="checkbox"/> Non-casino card to table games <input type="checkbox"/> Horse races <input type="checkbox"/> Sports betting	<input type="checkbox"/> Lottery tickets <input type="checkbox"/> Instant win or scratch tickets <input type="checkbox"/> Internet gambling <input type="checkbox"/> Gambling with stock market or real estate <input type="checkbox"/> Betting on games of skill <input type="checkbox"/> Betting on outcome or event <input type="checkbox"/> Other (please specify):

DATE THIS FORM WAS COMPLETED:

**THANK YOU FOR COMPLETING THE APPLICATION FORM**

<b>FOR OFFICE USE ONLY</b>
Has the assessment been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date the assessment was completed:
If no assessment was completed, please indicate why:
Admissions Staff Name:
Admissions Staff Signature: