Stonehenge
Therapeutic Community

Support. Hope. Thrive.

APPLICATION FOR RESIDENTIAL TREATMENT

INSTRUCTIONS:
1. Complete form electronically or print and complete by hand.
2. You may send the form by fax, mail or email. If you choose to email your completed form to info@stonehengetc.com please note that email is not a secure platform for confidentiality.
3. You **must call** the Stonehenge Office Coordinator to book your intake assessment 519-837-1470 x 221.

MAILING ADDRESS:	**FAX NUMBER: 519- 837-3232**	**PHONE NUMBER: 519-837-1470**
Stonehenge Therapeutic Community C/O Admissions 60 Westwood Road Guelph, ON N1H 7X3	Completed applications can be faxed to Please mark with 'Attention: Admissions'. **WEBSITE:** Detailed program and assessment information can be found at www.stonehengetc.com	ADMISSIONS COORDINATORS EXTENTIONS: Women's Health and Provincial Program x226 Men's Health and Provincial Program x227 Men's and Women's Federal Program x232 Office Coordinator x221

START APPLICATION HERE

PERSONAL INFORMATION		
First Name:	Last Name:	
Full name at birth (if different than above):	Preferred Name:	
Date of Birth:	Gender:	Pronouns:
Do you have an Ontario Health Card? ☐ Yes ☐ No	Health Card Number:	
Home Address:	City:	Province:
Postal Code:	Is this your permanent address? ☐ Yes ☐ No	
Phone Number:	Ok to leave a message? ☐ Yes ☐ No	
REFERRAL INFORMATION		
Please share how you were referred to Stonehenge:		
Contact name at referring agency(ies):		
CURRENT EMPLOYMENT STATUS:		
Please describe:		
EDUCATION: (HIGHEST LEVEL ACHIEVED):		
Please describe:		
INCOME SOURCE:		
☐ Disability Insurance ☐ Employment ☐ Employment Insurance (E.I.)	☐ Family Support ☐ Ontario Disability (ODSP) ☐ Ontario Works (OW)	☐ Other Insurance (excluding E.I.) ☐ Retirement Income ☐ Other
PREVIOUS TREATMENT INFORMATION		
Have you had previous substance use treatment? ☐ Yes ☐ No (if Yes, complete chart below)		

Treatment Facility/Location	Date Attended	Program Length	Completed?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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Have you had previous treatment at Stonehenge? ☐ Yes ☐ No If Yes, when:

Have you ever had periods when you were not using substances? If so, what coping strategies worked?

IDENTIFIED FAMILY

Which best describes your current relationship status?

☐ Not in significant relationship ☐ In a significant relationship/partnered ☐Married

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?

If you have children, please complete the chart below:

Name of Child	Age	Who do they live with?

LEGAL STATUS

Legal Status:

☐ N/A ☐ Awaiting Trial or Sentencing ☐On Probation ☐ On Parole ☐ Incarcerated

☐ Other, please specify:

Please list all prior convictions:

FPS#: OTIS#:

Do you have any charges, fines or warrants outstanding or pending? ☐ Yes ☐ No

If yes, please explain:

Are you currently participating in a Drug Treatment Court program? ☐ Yes ☐ No

If yes, please provide your Drug Treatment Court Worker's name:

Phone Number: Permission to contact? ☐ Yes ☐ No

PHYSICAL HEALTH STATUS

Family Doctor (if applicable): Phone Number:

Please check any that apply to you:

☐ Visual Impairment ☐ Mobility concerns ☐ Communicable diseases (e.g. Hepatitis, HIV)

☐ Hearing impairment ☐ Pregnant ☐ Acquired Brain Injury

Please describe your current physical health:

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MENTAL HEALTH STATUS
Have you received a mental health diagnosis by a mental health professional? Within the last 12 months? ☐ Yes ☐ No Within your lifetime? ☐ Yes ☐ No
If yes, please explain:
Have you ever attempted suicide? ☐ Yes ☐ No (if yes, when?):
Please describe your current mental health:

MEDICATIONS	
Please list your current medication(s):	Please indicate your current dosage(s):
1.	
2.	
3.	
4.	
5.	
6.	
7.	

OPIOID SUBSTITUTION
Are you currently participating in an opioid substitution program? ☐ No ☐ Yes (if yes, please indicate below) ☐ Methadone ☐Suboxone ☐ Sublocade

SUBSTANCE USE HISTORY

What substances are you currently using, and how frequently would you use each substance?

Substance	Frequency		Method of use
1.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	
2.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	
3.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	
4.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	
5.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	

SUBSTANCE USE HISTORY continued		
Please indicate any substances used in the past 12 months (select all that apply)		
Substance	Last Date Used	Method of Use
☐ Alcohol		
☐ Amphetamines and other stimulants		
☐ Barbiturates		
☐ Benzodiazepines		
☐ Cannabis		
☐ Cocaine		
☐ Crack		
☐ Ecstasy/MDMA		
☐ Glue/Inhalants		
☐ Hallucinogens		
☐ Heroin/Opium		
☐ Methamphetamines (e.g. crystal meth)		
☐ Other psychoactive substances		
☐ Over-the-counter Codeine		
☐ Prescription Opioids		
☐ Steroids		
☐ Tobacco		
☐ Other (please specify)		
DATE THIS FORM WAS COMPLETED:		

Thank you for filling out this form.