Stonehenge
Therapeutic Community

Support. Hope. Thrive.

APPLICATION FOR RESIDENTIAL TREATMENT

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:	**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 information on our programs and the assessment process can be found at www.stonehengetc.com	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? ☐ Yes ☐ No	Health Card Number:	
Home Address:	City:	Province:
Postal Code:	Do you have a fixed address? ☐ Yes ☐ No	
Phone Number:	Ok to leave a message? ☐ Yes ☐ No	
Emergency Contact:	Relationship:	
Emergency Contact Phone #:	Ok to leave a message? ☐ Yes ☐ 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:		
☐ Self	☐ Day/Evening Addiction Services	☐ Correctional Facility
☐ Family/Friend	☐ Psychiatric Services	☐ Non-Addictions Residential
☐ Initial Assessment Treatment Planning	☐ Psychiatrist/Psychologist	☐ Self-Help Group
☐ Withdrawal Management Centre	☐ Medical Services	☐ EAP/Employer
☐ Community Withdrawal Management	☐ Community Heath Centre	☐ Police
☐ Residential Addiction Treatment	☐ Physician/Private Practice	☐ Other Legal
☐ Supportive Housing	☐ Public Health Unit Nurse	☐ Connex Website
☐ Outpatient Addiction Services	☐ Community Mental Health	☐ Other

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EMPLOYMENT STATUS:		
☐ (Self) Employed Full-time ☐ Employed Part-time ☐ Unemployed (looking for work)	☐ Student/Re-training ☐ Disability	☐ Not in Labour Force (e.g. homemaker) ☐ Retired
EDUCATION: (HIGHEST LEVEL ACHIEVED):		
☐ No formal schooling ☐ Some Primary School ☐ Completed primary School	☐ Some Secondary or High School ☐ Completed Secondary or High School ☐ Some College/CEGEP/Nursing	☐ Completed College/CEGEP/Nursing ☐ Some University ☐ Completed University Degree/Masters/ PhD
INCOME SOURCE:		
☐ Disability Insurance ☐ Employment ☐ Employment Insurance (E.I.) ☐ Family Support	☐ None ☐ Ontario Disability (ODSP) ☐ Ontario Works (OW)	☐ Other Insurance (excluding E.I.) ☐ Retirement Income ☐ Other

PREVIOUS TREATMENT INFORMATION

Have you had previous substance use treatment? ☐ No ☐ Yes (if yes, complete chart below)

Treatment Facility/Location	Type of Treatment	Date Attended (mm/yyyy)	Program Length	Completed?
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

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

IDENTIFIED FAMILY

Please identify your current relationship status:

☐ Married ☐ Partnered/Common Law ☐Single (never married) ☐ Divorced/Separated ☐ 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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IDENTIFIED FAMILY continued

If you have children, please complete the chart below:

Name of Child	Age	Who do they live with?

Are you currently involved with any of the following services? Check all that apply:
☐ Family & Children's Services ☐ First Nations Family Services ☐ Other (please specify) :

LEGAL STATUS

Legal Status:
☐ No Problems ☐ Awaiting Trial or Sentencing ☐On Probation ☐ On Parole ☐ Incarcerated
☐ Other, please specify:

FPS#:	OTIS#:

Are you applying to Stonehenge for Parole? ☐ No ☐ Yes

If yes, please indicate type: ☐ Provincial ☐ Federal-Day Parole ☐ Federal-Full Parole

What is your Parole Eligibility date? (dd/mm/yyyy) :

If incarcerated, what institution are you currently at?

Probation/Parole Officer: Phone:

Lawyer: Phone:

Treatment Mandated or Required?
☐ None/No Conditions ☐ Choice of Treatment or Incarceration ☐ Condition of Probation/Parole
☐ Family & Children's Services Requirement ☐ Condition of Employment ☐ Condition of Family
☐ Other, please specify:

Do you currently have Young Offender status? ☐ No ☐ Yes

Do you have any charges, fines or warrants outstanding or pending? ☐ No ☐ Yes (if yes, please explain below)

Please list any upcoming court dates:

Please list all prior convictions	Year	Sentence	Juvenile	Adult
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Are you currently participating in a Drug Treatment Court program? ☐ No ☐ Yes
If yes, please provide your Drug Treatment Court Worker's name:
Phone Number: Permission to contact? ☐ No ☐ Yes

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

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MEDICATIONS	
Please list all 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 ☐ No ☐ Yes Within the last 12 months? ☐ No ☐ Yes Within your lifetime? ☐ No ☐ Yes

OPIOID SUBSTITUTION

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

☐ Methadone ☐ Suboxone ☐ 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 active substance use, how frequently would you use each substance?

Drug of Choice	Frequency in Active Substance Use		Method of Use	
1.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
2.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
3.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
4.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ Swallowed
5.	☐ 1-3 times monthly ☐ 1-2 times weekly ☐ 3-6 times weekly	☐ Daily ☐ Binge	☐ Smoked ☐ Snorted	☐ Injected ☐ 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?

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

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

DATE THIS FORM WAS COMPLETED:

THANK YOU FOR COMPLETING THE APPLICATION FORM

FOR OFFICE USE ONLY
Has the assessment been completed? ☐ Yes ☐ No
Date the assessment was completed:
If no assessment was completed, please indicate why:
Admissions Staff Name:
Admissions Staff Signature: