CENTRE JUBILEE CENTRE
CATALYST CLIENT INFORMATION

Case # _____ **Revised: Dec. 02.15**

First Name: _____ Last Name: _____ D.O.B.: _____ Age:____
(dd/mm/yyyy)

Gender: **F / M** Last Name at Birth: _____ Health Card #: _____

Band/Status Card No: _____

INTAKE DATE: _____ **INTAKE TIME:** _____

Address Effect. Date: _____ Address: _____ Apt:
Is this your mailing address Y/N **Your residence address Y/N**

City: _____ Province: _____ Postal Code: _____ County:

Home ☎: (____) _____ Other ☎: (____)
Okay to: Call **Y / N** Leave Msg. **Y / N** Okay to: Call **Y / N** Leave Msg. **Y / N**

Current residence location if different from above:

Accommodation(s) (residence type):

Hostel/Shelter	____	Private house/Apt.SR owned/Market Rent	____
No fixed address	____	Private house/Apt. Other subsidized	____
Rooming/Boarding	____	Municipal non-profit housing	____

Couch surfing Y/N If yes, please identify the residence type from the above category

Other:

Living arrangements:

Self	____	Children	____	Parents	____
Spouse/partner	____	Relative(s)	____	Non-relative(s)	____
Spouse/partner & others	____	Unknown or SR declined	____		

Preferred Language: _____ **Ethnicity:**

Emergency Contact: _____ Relation: _____ Home ☎: (____) _____
Other ☎: (____) _____

PW NAME (please print) **DATE:**

Referring Source AgencyType/Name:_____

Tel. ☎: (____)_____ Agency Contact_____

Fax: ( )_____

Referral date: _____ **Main Client** Y/N **Readmission** Y?N

Case Worker: _____

Presenting Issues (contact):

Accommodations	___	Educational	___	Life skills	___
Add/Subst.Abuse Relapse Prevention	___	Employment	___	Literacy issues	___
Add/Subst.Abuse Withdrawal	___	Emotional Mental Health/others	___	Parenting/Child	___
Add/Subst. Abuse by others	___	Emotional Mental Health/self	___	Physical Abuse victim	___
Add/Subst. Abuse by self	___	Financial	___	Physical health	___
Anger/Aggressive/Violence by self	___	Gambling	___	Sexual Abuse victim	___
Child Welfare involvement	___	Gambling by others	___	Social Isolation	___
Criminal Justice	___	Learning/Cognitive issues	___	Spousal/Partner	___
Eating Disorder	___	Legal	___	Suicidal	___

Substances Used in Past 12 Months (check as many as required) :

1.Alcohol	___	8. Crystal Meth	___	14. Other psychoactive drugs	___
2.Amphet./other stimulants	___	9. Ecstasy	___	15. OTC codeine prep.	___
3.Barbiturates	___	10, Glue/other inhalants	___	16. Prescription opiods	___
4.Benzodiazepines	___	11, Hallucinogens	___	17. Steroids	___
5.Cannabis	___	12. Heroin/Opium	___	18. Tobacco	___
6.Cocaine	___	13. None	___	19. Undifferentiated	___
7.Crack	___			20. Unknown	___

Presenting Problem Substances:

	Substance codes See above	**Frequency of use** In past 30 days
Major	_____	_____
1st other	_____	_____
2nd other	_____	_____
3rd other	_____	_____
4th other	_____	_____

1. Did not use
2. 1-3 times monthly
3. 1-2 times weekly
4. 3-6 times weekly
5. Daily
6. Binge
7. Unknown

PW NAME (please print) **DATE:**

Mandatory Treatment: Y / N
1. None
2. Choice between treatment or jail
3. Condition of probation/parole
4. Child Welfare Authority (C.A.S.)
5. Condition of Ontario Works
6. Condition of employment
7. Condition of school
8. Condition of family
9. Other

Charges Pending: Y / N
What are the charges: _____

Probation Start/End dates: _____ to _____

Highest level of Education attained: _____

Legal Status:
No legal problems _____
Pre-charge Diversion _____
Court Diversion Program _____
On bail – awaiting trial _____
On probation _____
On parole _____
Waiting trial or sentence _____ Other: _____

IF UNDER 18 Young Offender: Y / N

Correctional facility in past 6 months: Y /N **Location:** _____

Non-Medical Injection Drug Use: Never_____ Prior to 1 year_____ Past 12 months_____ Unknown_____

Relationship Status:
Married/partnered/common-law _____
Single _____
Widow or Widower _____
Separated _____
Divorced _____
Unknown _____

Employment Status (enter only one):
Self / Employed full time _____
Unemployed (looking for work) _____
Student/training _____
Disabled (not working) _____ Unknown _____
Not in labour force _____
Retired _____

Income Source:
Disability Insurance _____
Employment _____
Employment Insurance _____
None _____
ODSP _____
Family Support _____
Ontario Works _____
Other _____
Other insurance _____
Retirement income _____
Unknown _____

PW NAME (please print) **DATE:**

Family Physician: _____ **Tel.☎:** (____) _____
Number of Children: _____ **Age of Children in Client's Custody:** _____

MEDICAL

Number of overnight hospitalizations in the last 12 months for physical problems: _____Unknown _____
Reason for most recent hospitalization:

Diagnosed with a mental health problem by a qualified mental health professional:
Within last 12 months: **Yes** ___ **No** ___ **Unknown** ___ Most Recent Diagnosis #1:_____
Within lifetime: **Yes** ___ **No** ___ **Unknown** ___ Most Recent Diagnosis #2 _____

Hospitalized with a mental health problem: **Within the last12 months please complete:**

Within last 12 months: **Yes** ___ **No** ___ **Unknown** ___ **Adm date:**_____ **Disch. Date:**_____
Within Lifetime: **Yes** ___ **No** ___ **Unknown** ___ **Name of hospital**_____

Received Counselling/support/treatment for a mental health, emotional, behavioural or community mental health program
or professional:
Currently: **Yes** ___ **No** ___ **Unknown** ___ Name/☎of service provider:_____
Within last 12 months: **Yes** ___ **No** ___ **Unknown** ___ Within Lifetime: **Yes** ___ **No** ___ **Unknown** ___

Prescribed medication for a mental health problem:
Currently: Yes ___ No ___ Unknown ___ Within lifetime: Yes ___ No ___ Unknown ___
Within last 12 months: Yes ___ No ___ Unknown ___

Visual Impairment: Y/N Hearing Impairment: Y/N Mobility/Physical Impairment: Y/N Pregnant: Y/N or N/A

Problem Gambling: **Yes** _____ **No** _____ **Unknown** _____

Gambling Activities Engaged in the Past 12 months:

Bingo (live/TV/radio) _____	Slot machines _____	Gaming machines _____
Casino Card/Table Games_____	Informal/Illegal _____	Horse races(live/off-track)_____
Non-Casino Card/Table games___		
Sports betting _____	Lottery/Tickets _____	Instant win/scratch tickets _____
Internet gambling _____	Stock market/RealEstate _____	Games of skill _____
Outcome of events _____	Other (50/50 draw, pay cheque draw)_____	None _____
Unknown _____		

PW NAME (please print) **DATE:**

If answer to Problem Gambling is "Yes" what is treatment plan?

Declined treatment _____
Referred to designated gambling agency _____
Treatment plan not established _____
Not applicable _____
Treated within this agency _____

If answer to Problem Gambling is "Yes" and the Gambling form was not completed, please indicate reason:

Client declined treatment _____
Client refused _____
Deceased _____
Literacy issues/language barrier _____
Client dropped out/withdrew _____
Clinically inappropriate _____
Form filled out incorrectly by client _____

List all current prescribed medications/vitamins and their purpose(s):

Health Conditions/Problems:

Methadone/Opiod Substitute:

PW NAME (please print) **DATE:**