Ken Brown Recovery Home
APPLICATION FORM

(Please Print)

CLIENT INFORMATION			
First Name:	Middle Name:	Last Name:	
Last Name at Birth:	Alternate:		
Date of Birth: (dd/mm/yyyy) / / /	Age:	Gender: ☐ M ☐ F	
Health Card #:			
Street Address:			
City:	Province:	Country:	Postal Code:
☐ No Fixed Address	☐ Unknown Postal Code		
Home Phone: ( )	Telephone Call Allowed: ☐	Message Allowed: ☐	
Work/Other Phone: ( ) Ext:	Telephone Call Allowed: ☐	Message Allowed: ☐	

IN CASE OF EMERGENCY			
Name of friend or relative:	Relationship to client:	Home Phone No.: ( )	Work Phone No.: ( )
Preferred Language of Service:	English: ☐	French: ☐	Bilingual: ☐
Ethnicity:			

REFERRAL INFORMATION				
Referred to KBRH by (Please check one box):				
☐ Social/Family Services	☐ Treatment Centre	☐ Detox/Hospital	☐ Family	☐ Friend
☐ EAP	☐ Court	☐ Self	☐ Other (Specify)	
Referral Agency Name:	Street Address:	Phone: ( )	Fax: ( )	
P.O. Box:	City:	Province:	Postal Code:	
Are you a client/patient here?	☐ Yes	☐ No		

OTHER INFORMATION				
Legal Status (Please check one box):				
☐ No Problems	☐ On Probation	☐ Incarcerated	☐ On Parole	☐ Awaiting Trial/Sentencing
Treatment Mandated:				
Probation/Parole Officer Name:	Street Address:	Phone: ( )	Fax: ( )	
Conditions of Probation/Parole:				
If on Probation/Parole:	Date Started:	Date Finished:	FPS Number:	
Marital Status:	☐ Single/Never Married	☐ Married	☐ Separated/Divorced	☐ Widowed
Current Employment Status:	☐ Employed Full Time	☐ Employed Part Time	☐ Unemployed (Looking)	
	☐ Student/Training	☐ Disabled	☐ Retired	☐ Not in Labour Force

Education:	☐ No Formal Schooling	☐ Some Primary School	☐ Primary School
	☐ Some Secondary School	☐ Secondary School Completed	☐ Some College
☐ College Completed	☐ Some University	☐ University Completed	☐ Post Graduate

Current Income Source(s): (Please check applicable boxes):

☐ Wages or Salary ☐ Disability Pension ☐ Retirement Pension ☐ GWA ☐ WCB

☐ Employment Insurance (EI) ☐ FBA ☐ No Sources ☐ Other (Specify):

SUBSTANCE ABUSE ISSUES

Substance(s) Used in Last 30 Days - (In order of severity):

1st Substance:	Severity Code:	Severity Code: Fill blanks with the following codes. 01 = Did not use; 02 = 1 to 3 times per monthly; 03 = 1 to 2 times per week; 04 = 3 to 6 times per week 05 = daily 06 = binge
2nd Substance:	Severity Code:	
3rd Substance:	Severity Code:	

Substances Used in the Last 12 Months – (Please check appropriate boxes):

☐ Alcohol	☐ Cocaine	☐ Heroin/Opium	☐ Steroids
☐ Amphetamines (Stimulants)	☐ Crack	☐ Methamphetamines (Crystal Meth)	☐ Tobacco
☐ Barbiturates	☐ Ecstacy	☐ None	☐ Unknown
☐ Benzodiazepines	☐ Glue/Inhalants	☐ Over the Counter Codeine	☐ Other (Specify):
☐ Cannabis	☐ Hallucinogens	☐ Prescription Opioids	☐ Other (Specify):

Is their a history of substance abuse in your family (Specify):

GAMBLING ISSUES

Do you have a gambling problem?: ☐ Yes ☐ No

☐ Bingo	☐ Non Casino Card Table Games	☐ Internet Gambling	☐ Other (Specify):
☐ Slot Machines	☐ Sports Betting	☐ Stock Market/Real Estate	☐ Other (Specify):
☐ Gaming Machine	☐ Lottery Tickets	☐ Games of Skill	☐ None
☐ Casino Card Table Games	☐ Instant Win/Scratch	☐ Outcome of Events	☐ Unknown

HEALTH RELATED ISSUES

Please check any known personal health issues or concerns:

☐ Visually Impaired	☐ Chronic Pain	☐ Hepatitis C	☐ Respiratory
☐ Hearing Impaired	☐ Eating Disorders	☐ Head Injuries	☐ STD
☐ Mobility	☐ HIV/AIDS	☐ Seizures/Epilepsy	☐ Stomach/Gastrointestinal
☐ Allergies	☐ Heart Disease	☐ Lice/Scabies	☐ Tuberculosis
☐ Blood Pressure	☐ Hepatitis A	☐ Liver Disease	☐ Thyroid
☐ Cancer	☐ Hepatitis B	☐ Pancreatitis	☐ None

Is there any medical condition you feel we should be aware of: ☐ Yes ☐ No

If Yes above, please explain:

Intravenous Drug Use (IDU):

☐ Never Used	☐ In the past 12 Months	☐ Prior to 12 Months
Number of overnight hospitalizations in the last 12 months for physical problems:		
Reason for most recent hospitalization:		
Have you ever been diagnosed with a mental health problem by a qualified mental health professional?:		
Within last 12 months: ☐ Yes ☐ No	Within lifetime: ☐ Yes ☐ No	
Most Recent Mental Health Diagnosis: 1.	2.	
Hospitalized for a mental health problem?:		
Within last 12 months: ☐ Yes ☐ No	Within lifetime: ☐ Yes ☐ No	
Have you ever received treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?:		
Currently: ☐ Yes ☐ No	Within last 12 months: ☐ Yes ☐ No	Within lifetime: ☐ Yes ☐ No
Name of Service Provider:		
Medications that you are currently taking for ANY condition:		

Name of Medication:	Reason Prescribed:	Dosage/Frequency:	Prescribing Doctor's Name:
		/	
		/	
		/	
		/	
		/	

Are you currently on a Methadone Treatment: ☐ Yes ☐ No

TREATMENT HISTORY			
Have you attended a Drug/Alcohol Treatment Program: ☐ Yes ☐ No			If YES, please complete the following
Name of Centre:	Date Attended:	Length of Stay:	Completed: Yes/No; if No give reason
Have you been a resident of a Recovery Home Program: ☐ Yes ☐ No			If YES, please complete the following
Name of Recovery Home:	Date Attended:	Length of Stay:	Reason for Discharge:
Have you ever attended outpatient counseling for addiction: ☐ Yes ☐ No			If YES, please complete the following
Name of Agency:	Date Attended:	# of Sessions:	Outcome of Therapy:

PERSONAL GOALS & OBJECTIVES
How do you feel the Ken Brown Recovery Home can assist you in your recovery?:
Please describe three (3) specific goals/objectives which you would like to accomplish during your stay?: 1.
2.
3.

APPLICANT DECLARATION
The above information is true to the best of my knowledge. Any false or misleading information may result in the termination of this application and/or dismissal from the Program if found to be untrue at a later date. I hereby acknowledge the terms and conditions herein and if accepted, I will participate fully in the Ken Brown Recovery Programs _____ _____ *Client/Guardian signature* *Date*

FOR OFFICE USE ONLY	
Today's Date:	Chart/File #:
Admission Status:	Waitlist Status:

Please forward application to:

EXECUTIVE DIRECTOR
KEN BROWN RECOVERY HOME
8 Herrick Street
Sault Ste. Marie, Ontario
P6A 2T4
FAX # (705) 942 3472