

Sunshine Coast Health Center

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# Admission Package

Part 1 of 2



**Sunshine Coast  
Health Center**

# Client Admission Form

This is an interactive document. Simply place your cursor over the item you wish to fill in and begin typing.  
Please complete and submit online (see the SEND button on page 4). Alternatively you can print this document and fax to 1-604-487-9012. A staff member will contact you within 24 hours.

## Client (Patient) Information:

Name

(First) (Middle Initial) (Last)

Address

Street/PO Box

City/Town

Prov/State

Postal/Zip

Telephone Numbers

Home:

Cell:

Other (specify):

Email address:

Age

Date of Birth

Provincial Health Care No.

Requested Admission Date:

## Funding Guarantor (if different from client):

Name

(First) (Last)

Address

Street/PO Box

City/Town

Prov/State

Postal/Zip

Telephone Numbers

Home:

Work:

Relationship to client? self-pay EAP employer  
family member other

## Payment

How will you be paying? cheque money order  
wire transfer credit card

I acknowledge that I have read the Agreement of Responsibility for Residential Treatment Costs and agree to its terms.

## Source of Information (if different from Client or Guarantor):

Name of person completing this application:

(First) (Last)

Relationship to Client

Telephone Numbers

Home:

Work:

Cell:

## Referring Professional:

Were you referred to Sunshine Coast Health Center by one of the following professionals?

Therapist/Counsellor	Yes	No
Psychologist	Yes	No
Physician	Yes	No
Psychiatrist	Yes	No
Interventionist	Yes	No
Other	Yes	No

If yes, name of professional(s):

## 1. Precipitating Event/Motivation

Has a specific event(s) prompted this application?

Yes No

If yes, please describe.

Continued on next page

**2. Medical History (Biomedical Complications)**

Primary Physician

City/Town

Prov/State

Office Telephone Number

Have you had any medical conditions/illnesses within the past two years? Yes No

If yes, please identify.

Are you taking any prescribed medications? Yes No

Are you taking any over-the-counter drugs? Yes No

If yes to either question, please provide name, dosage, duration of use, and reason taken.

Have you been hospitalized in the past year? Yes No

Have you ever attempted suicide? Yes No

If yes to either question, please describe and provide date(s).

Please identify any known allergies.

Do you snore or have problems sleeping? Yes No

Are you able to walk, feed, dress and care for yourself independently? Yes No

**3. Psychological History (Emotional/Behavioral)**

Are you **currently** seeing a psychiatrist? Yes No

Name of psychiatrist?

Are you **currently** seeing:

Psychologist? Yes No

Counsellor? Yes No

Name of Professional:

City/Town Prov/State

Office Telephone Number

Have you had any psychological/emotional problems in the **past two years?** Yes No

If yes, please identify.

**4. Alcohol/Drug History**

Complete for alcohol or any other addictive substances you have used (including nicotine) in the **past 6 months**.

**Name of Drug**

Pattern of use (daily, weekend, binge)

Amount used per occasion

Length of use

Date of last use

**Name of Drug**

Pattern of use

Amount used per occasion

Length of use

Date of last use

**Name of Drug**

Pattern of use

Amount used per occasion

Length of use

Date of last use

**Name of Drug**

Pattern of use

Amount used per occasion

Length of use

Date of last use

**5. Treatment History**

Have you previously been to treatment?

Yes No

If "Yes," please detail the history. If you require more space, please insert extra page(s).

**Name of Program**

Where located

When

Inpatient or residential?

Was Program Twelve-Step based? Yes No

Did you complete the program? Yes No

If "No," how come?

Outcome (length of abstinence)

**Name of Program**

Where located

When

Inpatient or residential?

Was Program Twelve-Step based? Yes No

Did you complete the program? Yes No

If "No," how come?

Outcome (length of abstinence)

**Name of Program**

Where located

When

Inpatient or residential?

Was Program Twelve-Step based? Yes No

Did you complete the program? Yes No

If "No," how come?

Outcome (length of abstinence)

**6. Family**

Current marital status?    Single    Married  
   Divorced    Separated    Widowed

Ages of children?

Is there a family history of alcohol/drug use or dependence?    Yes    No

If yes, please describe.

**7. Employment Status**

Current employment status?  
   Employed    Unemployed

Length of current status

If employed, please describe nature of job.

Please describe impact of alcohol/drug use on employment history.

**8. Legal History**

Have you ever been charged or convicted with a Criminal Code offence(\*)?  
   Yes    No

(\*)Note: for American applicants, Criminal Code offences refer to misdemeanor or felony convictions.

If yes, please describe (include DUIs).

If yes, do you have any pending hearings?  
   Yes    No

**9. Nutrition**

Do you have any special dietary concerns?  
   Yes    No

If yes, please describe.

**10. Recovery**

Please identify any strengths or resources for recovery, e.g., family support, employer support, personally motivated, etc.

Please identify any current obstacles to treatment or recovery.

**Thank you.** If you have any questions regarding this application or prefer to complete the questionnaire over the phone, please contact us toll-free at 1-866-487-9010.

**For Office Use Only**

RP     I     GAW     Y     WM     A     O

**Click here to submit this form online.**