

Client Admissions Form



LDR Holistic Treatment Inc.

Helping People One Step At A Time

Client Admission Form

1. Participant Information

Name

(first) (Middle) (last)

Address

City/Town

Prov/State

Postal/Zip

Current marital status? Single Divorced
 Married Separated Widowed

2. Contact Information

Home

Cell

Other

Email:

3. Medical History

Primary Physician Name

Physician Contact Number

Physician fax Number

Have you had any medical conditions / treatment within the past 3 years?

Yes No

If yes please explain:

Are you taking any prescribed medications:

Yes No

Medication Name

Dosage

Length of time on medication

Please continue to the next page

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3. MEDICAL HISTORY CONT.

Have you been admitted into any psychiatric care in the past 6 months?

Yes No

If yes please explain (Length of stay):

Have you attempted suicide in the past 6 months?

Yes No

If yes please describe and provide date(s):

Do you have any food or drug allergies?

Yes No

If yes please describe:

Have you been admitted into any psychiatric care within the past 6 months?

Yes No

If yes please explain (Length of stay):

Are you currently involved with one or more of the following?

	Yes	No
1. Addiction Specialist	<input type="checkbox"/>	<input type="checkbox"/>
2. Counsellor	<input type="checkbox"/>	<input type="checkbox"/>
3. Interventionist	<input type="checkbox"/>	<input type="checkbox"/>
4. Psychologist	<input type="checkbox"/>	<input type="checkbox"/>

Please provide the professional/s name:

Name	Number (include area code)
1.	
2.	
3.	
4.	

Please be advised that we are not going to contact any of the persons listed in this form with out direct permission. If you have any questions regarding this admissions form please contact admin at 1 866 649-3949

Please continue to the next page

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4. Personal Information

Children Yes No

How many?

Ages of children:

Who do you feel is currently in your **healthy** support system?

Name	Relationship
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- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

5. Employment Status

Are you currently employed Yes No

If, yes how long employed with this employer _____

Is your employer requesting that you seek treatment for dependency issues Yes

Are you currently on a leave of absences due to medical or disability Yes

Are you seeking treatment as part of a plan outline in your DOT Assessment Yes

6. Dependency History

Name of Drug (including alcohol)

Length of use

Date of last use

Name of Drug

Length of use

Date of last use

Name of Drug

Length of use

Date of last use

Name of Drug

Length of use

Date of last use

Have you been admitted into a detox facility before Yes

When

Detox Facility

- 1.
- 2.
- 3.

Please continue to the next page

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7. Addiction Treatment

Have you been to treatment before, this includes day treatment or out patient programs Yes No

If yes, please provide more detail information below:

Treatment Program:

Date attended:

Length of program

Did you complete the program? If no please provide detail as to why not:

Treatment Program:

Date attended:

Length of program

Did you complete the program? If no please provide detail as to why not:

Treatment Program:

Date attended:

Length of program

Did you complete the program? If no please provide detail as to why not:

Please tell us what is the longest period of time you have been totally abstinence for all mood altering drugs (includes alcohol).

LDR Holistic Treatment Services, understands that this information can be very sensitive and sometimes can be very hard to write down. This information will be protected and remain confidential unless direct permission with a signed release of information form has been signed by the client. If you would like one of our intake workers to help you complete this form, please call us directly.

Administration: 604 530-9508

Toll Free: 1 866 649-3969

Fax: 1 866 753-2536

Email: admin@ldrholic.com

Website: www.holisticdrugrehab.org