



RAAM Intake Form

Part 1: General Information

Last Name: _____ First Name: _____ Alternate Name: _____

Gender: _____ Language(s) spoken: _____ Interpreter Required: Y N

Address: _____

Next of Kin (name/contact): _____

Are you at risk of losing your housing? Y N

Not homeless Homeless no address Shelter Other temporary shelter: _____

Phone #: _____ Work #: _____

May we leave a message? Yes No

Date of Birth: _____ Age: _____

Health Card Number: _____ Version Code: _____ Expiry Date: _____

Federal Interim Health #: _____ Other Health Coverage/Insurance: _____

Income source: Employment Employment Insurance Disability Insurance Family Support

Ontario Disability Support Program Ontario Works None Other: _____

How did you hear about us? Referral: _____

Emergency Department Other Health Provider Website Newspaper/Media

Other: _____

Primary Care Provider (e.g. Physician or NP): Yes No

Name: _____ Location: _____

Pharmacy Name: _____ Location: _____

Allergies: _____ Current Medications: _____

Part 2: Socio-Demographic Information (Optional – Part 2 only)

Sexual Orientation: Bisexual Gay Heterosexual Lesbian Queer Two-Spirit

Prefer not to answer Other: _____



Gender: Female Male Intersex Trans-Male to Female Trans-Female to Male
 Two-Spirit Prefer not to answer Other: _____

Racial/Ethnic Group: Asian Black First Nations White Latin Mixed Heritage
 Prefer not to answer Other: _____

What is your highest level of Education? Primary (K-8) Secondary (9-12/13) College
 University Bachelors University Post Grad No formal education Prefer not to answer
 Other: _____

How much money do you make in a year? (whole household) Don't know <\$14 999
 \$15 000-19 999 \$20 000-24 999 \$25 000-29 999 \$30 000-34 999 \$35 000-39 999
 \$40 000-59 999 \$60 000 – 89 999 \$ 90 000 – 119 999 \$120 000-149 000 150 000+

How many people help bring in this income? ____ How many people are supported by this income? ____

Who lives with you? Couple with child(ren) Couple without child(ren) Sole member
 Grandparents with grandchild(ren) Extended family Siblings Unrelated house mates
 Single Parent Other _____

Parenting: Are you parenting, pregnant, or a caregiver for a child under the age of 18? Yes No

Disabilities: Chronic illness Developmental Disability Drug or Alcohol dependence
 Learning Disability Mental Illness Physical Disability Sensory Disability None
 Other: _____ Do not know Prefer not to answer

Part 3: Admission Information (please check [√] ALL that apply):

What concern are you seeking help for?

Alcohol Drug Gambling Gaming Internet Unsure/None of the above

How ready are you to make changes to your alcohol/dug/gaming/gambling/internet use? (please circle a number from 1-10)

Not Ready									Ready
1	2	3	4	5	6	7	8	9	10



Please check [√] **ONE** for each category:

Legal Status: No Problem Awaiting Trial or Sentence Probation Parole Incarcerated
 Other

Young Offender: Yes No

Substance Use Concerns: Yes (please [√] **ALL** that apply) No

- | | |
|---|---|
| <input type="checkbox"/> Alcohol (Beer, Wine, Spirits) | <input type="checkbox"/> Hallucinogens |
| <input type="checkbox"/> Amphetamines (Adderall, Concerta) | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Methamphetamines (Crystal Meth) |
| <input type="checkbox"/> Benzodiazepines (Xanax, Lorazepam, Valium) | <input type="checkbox"/> Other Psychoactive Drugs |
| <input type="checkbox"/> Cannabis (Marijuana, CBD) | <input type="checkbox"/> Over-The-Counter Codeine (Tylenol 1) |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Opioids (fentanyl, morphine, dilaudid, heroin) |
| <input type="checkbox"/> Crack | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Glue & Other Inhalants |

Gambling Concerns: Yes No Comments: _____

Gaming/Internet/Technology Concerns: Yes No Comments: _____

Part 4: Health Status (please fill in EACH question [√])

- A. Physical Health Status:** Vision Impairment Hearing Impairment Mobility/Physical Impairment I am Pregnant
- B. Non-Medical Intravenous Drug Use:** Never Injected Injected Prior to 1 year Ago
 Injected in the Last 12 months
- C. Have you ever shared equipment?** Yes No
- D. Number of overnight hospitalizations in the last 12 months:**

- E. Diagnosed with mental health problem by a qualified mental health professional?**
 Yes No Within Last 12 months
 Yes No Within Lifetime
- F. Hospitalized for a mental health problem?**
 Yes No Within Last 12 months
 Yes No Within Lifetime

G. Have you every received counselling/treatment/support for a mental health, emotional behavioural or psychological problem?

- Yes No Currently
- Yes No Within Last 12 Months
- Yes No Within Lifetime

H. Have you ever been prescribed medication for a mental health problem?

- Yes No Currently
- Yes No Within Last 12 months
- Yes No Within Lifetime

I. Have you ever had seizures? Yes No

J. Please list any other health problems (i.e. Blood pressure problems, Cancer, Diabetes, Endocarditis, Heart problems, HIV/AIDS, Hepatitis, Kidney disease, Asthma, Migraine headaches, etc.):

K. Do you have any immediate safety concerns that you would like assistance with today or soon? Yes No

L. Have you ever had a concerning hit to your head, been hit on the head and/or experienced multiple, repeated impacts to your head?

- Yes No

M. Have you ever been in the emergency room, hospital, or by a doctor because of an injury to your head or neck?

- Yes No

N. Did you ever lose consciousness (including as a result of overdose) or experience a period of being dazed or did you have a gap in memory from the injury?

- Yes No

O. Are you currently taking Naltrexone?

- Yes No

P. Are you currently taking Methadone/Suboxone?

- Yes No

Q. Do you have a Naloxone Kit?

- Yes No

R. Have you ever attended any addiction treatment programs?

- Yes No (If yes, please list):

S. Other information that we should know?
