RAAM Intake Form

Part 1: General Information

Last Name: _______________ First Name: _______________ Alternate Name: _________________

Gender: ______________ Pronouns: _______________ Language(s) spoken: __________________

Address: ____ ☐ No Fixed Address

Phone #: ___________________ Work #: __________________

May we leave a message? ☐ Yes ☐ No

Date of Birth: ________________ Age: _______________

Health Card Number: ____________________ **Version Code:** _______ **Expiry Date**: __________

Federal Interim Health #: ____________________ ☐ No Insurance

Other Health Coverage: _____________________________________

How did you hear about us? ☐ Referral: __________________________________

☐ Emergency Department ☐ Other Health Provider ☐ Website ☐ Newspaper/Media

☐ Other: ____

Primary Care Provider (Physician or NP): ☐ Yes ☐ No

Name: __________________________ Location: _______________________________________

Pharmacy Name: __________________ Location: _______________________________________

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

Sexual Orientation: ☐ Prefer not to answer ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Queer

☐ Two-Spirit ☐ Other: ________________

Gender: ☐ Prefer not to answer ☐ ☐ Female ☐ Intersex ☐ Male ☐ Trans-Male ☐ Trans-Female

☐ Two-Spirit Gender not listed: ________________

Racial/Ethnic Group: ☐ Canadian ☐ French-Canadian ☐Aboriginal-Status ☐ Aboriginal- Non-Status

☐Prefer not to answer ☐ Other: ____

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

How much money do you make in a year? (whole household) ☐ Don't know ☐<$15 000 ☐$15 000-20 000 ☐$20 000-25 000 ☐$25 000-30 000 ☐$30 000-35 000 ☐ $35 000-40 000 ☐ $40 000-60 000 ☐$60 000+

How many people help bring in this income? __________________

How many people are supported by this income? ______________

Income Source: ☐Employment ☐ Employment Insurance ☐Disability Insurance ☐Family Support ☐ Ontario Disability Support Program ☐Ontario Works ☐ None ☐Other: ________________________

Relationship Status: ☐Married/Common Law ☐Single (Never married) ☐Widow/Widower ☐Separated or Divorced

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

Describe your home: ☐ House ☐Apartment ☐Homeless ☐Shelter ☐Other Temporary Shelter

Disabilities: ☐ Developmental Disability ☐ Learning Disability ☐ Physical Disability ☐Sensory Disability ☐None ☐Other: ____

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

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Young Offender: ☐ Yes ☐ No

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

☐Alcohol (Beer, Wine, Spirits) ☐ Hallucinogens

☐Amphetamines (Adderall, Concerta) ☐Tobacco

☐ Barbituates ☐ Methamphetamines (Crystal Meth)

☐Benzodiazepines (Xanax, Lorazepam, Valium) ☐ Other Psychoactive Drugs

☐Cannabis (Marijuana, CBD) ☐Over-The-Counter Codeine (Tylenol 1)

☐ Cocaine ☐ Opioids (fentanyl, morphine, dilaudid, heroin)

☐ Crack ☐ Steroids

☐ Ecstasy ☐ 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?**

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☐ 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?

____