



TOGETHER WE CAN

Drug & Alcohol Recovery & Education Society

2831 Kingsway, Vancouver BC V5R 5H9
 Tel: (604) 451 - 9854 Fax: (604) 451 - 8863
 Web Site: www.TWCvancouver.org
 Email: info@TWCvancouver.org

PART 3 – PHYSICAL HEALTH

Medical Diagnoses / Major Illnesses: Any diagnosed conditions/illnesses eg MS/Diabetes/Meningitis, Emphysema

Other Current Physical Health Issues such as cold, influenza or chronic conditions as back/knee pain, Migraines

Communicable Diseases None Reported TB HIV Hep A B or C Other _____
 Last Date Tested _____

Physician for pre-natal care _____ Tel _____

Relevant Medical History / Prior Hospitalizations

Family History

Operations

Current Medications (prescription, OTC, supplements)

Name	Condition Being Treated	Current RX Date	How Long on This

Methadone Maintenance Therapy Never
 Past **Current**
 When _____ How Long on MMT _____
 How Long on MMT _____ Current Dose _____
 Dose _____ Maintenance Reduction Carry Privileges Yes No
 Prescribing Physician _____ Name _____ Tel _____

Allergies (drug, food, environmental – include reactions) _____

Special Needs / Disabilities _____

Special Aids Used _____



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PART 4 – MENTAL HEALTH

Mental Health History / Symptoms (include psychiatric diagnoses, hospitalizations, other treatment)

Have you ever seen a psychiatrist? Been Diagnosed with a mental illness? Who diagnosed you and when? What are your symptoms? Are you on medications? What and for how long? Are the medications managing your symptoms? Do you take your medication(s) consistently? If you hear voices, what is the content?

Self-Harming Behaviours (eating disorders, slashing, burning)

Past or current behaviours? If you have had a current event, what happened? Have you had any help in the past?

Suicide Risk current ideation previous attempts When/What happened? Hospitalization? Family history?

Current Mood / Presenting Symptoms

Reported: _____

Professional Observations: how do you see client's mood? E.g. flat, fearful? _____



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PART 5 - ADDICTIONS

Substance Use History Fill in for each substance Enter "0" if not applicable	Method: 1 = Oral 2 = Snort/Sniff 3 = Smoke/Chase 4 = Intravenous 5 = Intramuscular	Amount	Frequency	Years of Use	Date Last Used
Alcohol					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Crack					
Crystal Meth					
Ecstasy					
Hallucinogens					
Heroin					
Illicit Methadone					
Inhalants					
Nicotine					
Opiates other than heroin/methadone					
Misuse of other Prescription Meds					
Speedball (Cocaine/Heroin)					

Other Addictions (sex, food, gambling, etc)

Previous Addictions Support / Treatment

Agency (Name)	Dates	Outcomes	Comments



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PART 6 - PROFESSIONALS INVOLVED

	Name	Agency / Office	Tel
Physician (G.P.)			
Addictions Physician			
Psychiatrist			
Mental Health Team			
A & D Counselling			
Health Centre			
Dual Diagnosis			
IA (MEIA)			
MCFD Social Worker			
Legal			
Parole / Probation			
Other Counsellor			

PART 7 - VERIFICATION

Client Authorization

I _____, verify that the information provided here is true to the best of my knowledge.
 Print Name

I understand that the information in this assessment will be shared with Together We Can professional staff involved in my care.

I understand that the financial information in this assessment will be verified by Together We Can before admission into the program and give my release to Together We Can to confirm funding as per information provided.

Client Signature _____ **Date** ____/____/____
DD MM YY

Staff Verification if Applicable

Completed by _____ Site _____
 Please Print

Staff Signature _____ Date ____/____/____
Day Month Year