NATIVE ADDICTIONS COUNCIL OF MANITOBA

OUTREACH REGISTRATION PROGRAM

INTAKE/REFERRAL APPLICATION QUESTIONNAIRE

Name: ___________________________

Treatment History:

Has the client participated in a non-residential/community based substance abuse program? **Yes / No**

Has client participated in a non-residential/community based mental health program? **Yes / No**

Has client participated in a residential treatment program before? **Yes / No**

If yes, please provide information on previous treatment experiences.

Year	Treatment Centre	Type of addiction	Completed	Comments

Mental Health Issues:

Has client been diagnosed with a mental illness? If yes, please describe.

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Has client had previous suicide attempts? If yes, when?

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Has client been hospitalized for suicide attempts? If yes, when?

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Is client currently suicidal? If yes, name of psychiatrist/psychologist (if applicable).

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