9889 140 Street, Surrey BC V3T 4M4
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ASSESSMENT FOR BOT SUPPORT RECOVERY

PART 1 – PERSONAL INFORMATION

Client Last Name _____ First

SIN # _____ **Date Of Birth** ____ (DD) / ____ (MM) / ____ (YY) **Age** ____

Gender ID M ☐ Transgender ☐ PHN# ____ - ____ - ____

Cultural / Ethnic ID _____ **Other Language**(s) _____

Address _____ Postal Code

Contact # 1 _____ 2 _____ Message ☐ Yes ☐ No

Emergency Contact _____ (Name) _____ (Relationship) _____ (Tel) Message ☐ Yes ☐ No

Dependent Children (enter # of children in box)
None reported ☐ Living with client ☐ Living with separated spouse/partner ☐
Living with family member ☐ In foster care ☐ Other _____

Employment Status Full-time ☐ Part-time ☐ Unemployed ☐

Income Status Employment ☐ EI ☐ Pension ☐ IA ☐ IA Application Date _____
Financial information for per diem funding must be confirmed before admission into the BOT Program

Per Diem Coverage Self ☐ IA ☐ ADS Subsidy ☐ Other _____

PART 2 – CURRENT STATUS

Current Situation / Areas of Concern (including crisis or circumstances leading to treatment)

Priority? No ☐ In Detox ☐ Pregnant ☐ Homeless ☐ HIV+ /Other Health Issues ☐

Other Crises _____

Safety Concerns / History or Current Violence in Relationships

Legal None Reported ☐ Pending Court Dates _____

Charges _____

Convictions Sexual Offences ☐ Violent Crimes (eg, weapons, assaults) ☐

Outstanding Warrants (what/where) _____

Probation/Parole (how long/conditions) _____

Know anybody in a support recovery facility now? No ☐ Yes ☐ Facility Name _____

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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	Dosage and Frequency	Current RX Date	How Long on This

Methadone Maintenance Therapy **Never** ☐

Past ☐
When _____
How Long on MMT _____
Dose _____

Current ☐
How Long on MMT _____
Current 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? _____

_____

BACK ON TRACK recovery

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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 Back On Track professional staff involved in my care.

I understand that the financial information in this assessment will be verified by Back on Track before admission into the program and give my release to Back On Track 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