Application for Mobile Treatment

1. Application form and signed by client.

Legal Name (last, first, middle)			
Other Name(s) Used:		Other Last Name Used:	
Date of Birth (yyyy-mm-dd)	Treaty Number	Age	☐ Male ☐ Female ☐ Transgender
Mailing Address:		City/Town:	
Street Address:		Postal Code:	
Primary Phone:		Secondary Phone:	
If you do not have a phone, where can we contact or leave a message for you?		Email:	

Marital Status (Please check one box only):

☐ Single/Never married ☐ Common Law ☐ Divorced

☐ Married ☐ Separated ☐ Widowed

Is childcare required for you to participate in mobile treatment? **YES NO**	Do you require transportation to participate in mobile treatment? **YES NO**
Next of Kin to be notified in case of emergency	Relationship to applicant
Primary Phone Number:	Secondary Phone Number:

Please describe in detail your alcohol, other drug use and/or gambling

What substances do you primarily use?
What do you use most often? Pattern of use (e.g. daily, binge)
How long have you used this substance?
Any medical concerns/conditions? If yes, please identify.
Are you on any medications, please list.

Client signature:

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