2022

Intake for Treatment Package

Nimkee Nupigawagan

Healing Centre

1/1/2022

NIMKEE NUPIGAWAN HEALING CENTRE

GENERAL INFORMATION

Date:	**Date of Birth:** ____(DD)/____(MM)/____(YYYY)
____(DD)/____(MM)/____(YYYY) **Clients First Nation:**	**Age:**___

If by Referral, who is making the referral?

Name:_____

Agency Name: _____

Role:_____

Phone #:_____Email:_____ Fax #: _____

How many sessions have you had with the client?___

Will you continue to support your client through and after their stay at the Treatment Facility? Yes ☐ No ☐

Picture (can be taken later upon entry)

CLIENT INFORMATION

Legal Name:		
Social Insurance Number:		Health Card Number:
Street Address:		
City:	Province:	Postal Code:
Telephone:		Email:
Status Card Copy (front/back)		Spirit Name: Nation:

CLIENT INFORMATION - CONTINUED

Client name: Date:

Should I leave Nimkee Nupigawagan prior to program completion, I agree to utilize the support of Nimkee Nupigawagan staff for resource information, and safe exit/transition planning and:

□ Return to my home and/or the home of the individual named below for immediate shelter and transition support; and/or

□ Contact the agency/worker named below for immediate shelter and transition support.

EMERGENCY CONTACTS			
Name	Relationship	Phone	Email
Priority 1)			
Priority 2)			
Priority 3)			

Do you have any children under 19? Yes ☐ No ☐ Are they living with you? Yes ☐ No ☐

Is Child Welfare involved with your family? Yes ☐ No ☐ Please provide additional info, if necessary:

CHILD WELFARE INVOLVEMENT OF PARTICIPANT (under age 21)

Crown Ward	
Indigenous Child Welfare Agency	
Details (worker, agency name, background)	

CULTURAL INFORMATION

We invite you to let us know if there are any traditional practices or ceremonies that will support your wellness while at Nimkee:

Is there anything you would like us to know that we have not included here about you or your culture practice/community?

Do you identify yourself as an Indigenous person, that is First Nations, Metis or Inuit? First Nations ☐ Metis ☐ Inuit ☐

Status: Yes ☐ No ☐ Band:_____

Have you participated in any traditional indigenous ceremonies prior to treatment (please check or x choices)			
Traditional Healer		Fasting /Fasting Camp	
Sundance		Healing Circles	
Full Moon Ceremony		Sacred Fire	
Sweatlodge		Helper	
Other:		Other:	
What types of indigenous crafts have you tried or want to try (circle or check):			
Beading	Ribbon Skirt/Shirt	Dreamcatchers	Art
Medicine bundles	Regalia	Sewing	Carving

WE will have each person fill out this questionnaire on strengths, interests and hopes because we hope that people can actively reflect. We will also enlist the help of other friends and family to assist us- we will provide forms to each person that the applicant identifies. It will be 1) family member, 1) friend and 1) sibling (if available).

CLIENT'S STRENGTHS, INTERESTS, HOPES

Tell us about your strengths and positive qualities- Look within yourself or think about what others have complimented you on- everyone is good at something, everyone has gifts. Tell us about your gifts and your positive attributes.

Tell us about your interests, talents and passions. What do you like to do? What have you done in the past that has brought you excitement and good feelings in mind, body, heart?:

Tell us about your hopes for treatment- Why do you want to attend treatment? (Try to write at least a few paragraphs so that we can look at your reasons)

SUBSTANCE USE TREATMENT HISTORY

Client name: Date:

Have you completed a withdrawal management program (including home detox, daytox) in past?

Yes No

If yes, please list most recent dates, where, and for what substances:

Have you ever participated in substance use services and supports (including counsellor, NNADAP, outpatient clinic, AA, NA, etc)? Yes No

If yes, please list most recent dates, where, and what substances you were using at the time:

What has been helpful in your past recovery or support experiences, including First Nation/Indigenous Support Services?

What has been unhelpful in your past treatment or support experiences, including First Nation/Indigenous Support Services?

GENDER AND SEXUAL ORIENTATION

Nimkee is a gender-separated service. Respectful of gender diversity, we will work with clients to figure out how to provide services in this setting which will be mutually respectful according to applicants self- identified gender and sexual orientation. Gender is diverse and we invite you to let us know what gender you identify with:

Male Female Gender Creative/Fluid Transgender: MTF FTM Other:_____Prefer not to answer

What pronoun would you like us to use? He She They Other: _____

Sexual orientation is diverse and we invite you to let us know your sexual orientation:

Heterosexual Lesbian Gay Bisexual Queer Questioning
Two-Spirit Pansexual Asexual Other:_____Prefer not to answer

Is your reason for getting help (substance use, mental health concerns) related to any issues around your sexual orientation or gender identity?

Not at all A little Somewhat A lot Unsure Prefer not to answer

*NOTE- Upon acceptance to the program, this section will be reviewed with applicant. _____ initial _____date

SUBSTANCE MISUSE							
Client name:				Referral Date:			
Primary Problem Rate (1-5) 1-Low problem 5- Major problem	**Substance**	**Primary Route of use** (Oral, nasal, Sublingual, Smoke, inhale, anal, intravenous, intra muscular, transbuccal	**# of days used in last 30 days**	**Amount Used in a Typical Day**	**Age at First Use**	**Current Use**	**Stage of Change Event**
	Alcohol						
	Tobacco						
	Cannabis						
	Crack Cocaine						
	Cocaine						
	Heroin						
	Opiates						
	Solvents						
	Crystal Meth						
	Amphetamines						
	Club Drugs						
	Hallucinogens						
	Inhalants						
	Over the Counter						
	Other Rx Meds						
	Methadone						

Client name:	Date:

Have you ever accidentally overdosed? *Yes* *No*

If yes, please tell us briefly about the most recent date this happened:

Have you ever experienced alcohol-poisoning, including black-outs /pass-outs? *Yes* *No*

Tell us about this experience (when/where/outcome)

OTHER PROBLEMATIC BEHAVIOURS

Do you or anyone in your life have concerns that you might have problems with any of the following behaviours (that is, you spend a lot of time, spend more money than you intended and/or it's interfering with other responsibilities)?

	Yes	No	Hours per day/Days per month
Shopping			
Sexual activity			
Gambling			
Gaming			
Other (Internet Overuse, Shoplifting, Theft, or _____)			

CLIENT'S HEALTH

Immunizations (attach all- **including immunization for Covid-19**)

Are you pregnant? Yes ☐ No ☐ Unsure ☐ N/A ☐	Number of weeks pregnant:
Do you have a history of seizures? Yes ☐ No ☐	Date of last seizure:

If yes, please let us know the cause of the seizures, if known (substance use related?):

Do you have any of the following, ongoing, health conditions?

Asthma ☐ breathing problems ☐ heart problems ☐ circulatory issues ☐ stomach problems ☐ Anxiety ☐

Do you take medication for these conditions? If so, what?

Do you have diabetes? Yes ☐ No ☐ If yes, is it managed with meds? Yes ☐ No ☐

Do you have any allergies? Yes ☐ No ☐ What is required to manage your allergies?

Do you require an epi-pen for allergies? Yes ☐ No ☐

Client name: Date:

Do you have any special dietary needs? Yes ☐ No ☐ If yes, please describe:

Do you have any mobility issues? Yes ☐ No ☐

If yes, please tell us briefly about your mobility concerns/needs:

MENTAL HEALTH

Do you have any mental health concerns? Yes ☐ No ☐

What are your concerns?

Have you received a mental health diagnosis? Yes ☐ No ☐ If yes, please elaborate:

Are you on medications for mental health concerns? Yes ☐ No ☐

What medication are you on?

Is this medication helpful? Yes ☐ No ☐ Please comment:

When was the last time you had significant problems with…

1. Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?
   Past month ☐ 2-3 mo's ago ☐ 4-12 mo's ago ☐ 1+year ago ☐ Never ☐
2. Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?
   Past month ☐ 2-3 mo's ago ☐ 4-12 mo's ago ☐ 1+year ago ☐ Never ☐
3. Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?
   Past month ☐ 2-3 mo's ago ☐ 4-12 mo's ago ☐ 1+year ago ☐ Never ☐
4. Becoming very distressed and upset when something reminded you of the past?
   Past month ☐ 2-3 mo's ago ☐ 4-12 mo's ago ☐ 1+year ago ☐ Never ☐
5. Seeing or hearing things that no one else could see or hear, or feeling that someone else could read or control your thoughts?
   Past month ☐ 2-3 mo's ago ☐ 4-12 mo's ago ☐ 1+year ago ☐ Never ☐

Client name:	Date:

MENTAL HEALTH – CONTINUED

Do you have any history of disordered eating? Yes ☐ No ☐ If yes, please elaborate:

Binging Purging Restricting Laxatives Excessive exercising Other, please describe:

Have you ever participated in treatment for disordered eating? Yes No

If yes, please tell us briefly about this:

Is the disordered eating still active? Yes ☐ No ☐	If no, when was it last active?

Do you engage in self-harming behaviours (cutting, burning, scratching)? Yes ☐ No ☐

If yes, is self-harm currently active? Yes ☐ No ☐ Please comment:

Do you have thoughts of suicide? Yes ☐ No ☐ Not Assessed If yes, do you have a

current plan for suicide? Yes ☐ No ☐ If yes, please elaborate:

Have you ever attempted suicide? Yes ☐ No ☐
If yes, date of most recent attempt:

Have you experienced a head injury or head trauma Yes ☐ No ☐ Please explain current head injury related concerns:

Do you often feel confused or overwhelmed in new places? Yes ☐ No ☐ If yes, please tell us more information about this:

Client name: Date:

CURRENT MEDICATIONS

Note: We will need verification from a medical practitioner. A consent form is attached (see Physical Form that is required)

Do you have any concerns about your current medications?

Are you on current opiate maintenance therapy? Yes ☐ No ☐ Which therapy?

Who is your care provider?

Start Date: Current Dose:

Current Opiate Maintenance Therapy Details:

PSYCHOLOGICAL & SOCIAL

Have you ever experienced problems controlling your anger / aggression? Yes ☐ No ☐
If yes, please tell us briefly about any anger or aggression concerns that are current or in the recent past:

Are you currently experiencing violence (including domestic violence or intimate partner violence)? Yes ☐ No ☐
Have you experienced violence in the past? Yes ☐ No ☐
If yes, please tell us briefly about any concerns related to your current safety:

Do you have concerns for your safety related to your care in this program? Yes ☐ No ☐. Please elaborate:

Do you have safety concerns related to aftercare? Yes ☐ No ☐. Please elaborate:

Do you have any concerns about being in a group setting/environment? Yes ☐ No ☐. Please elaborate:

Client name: Date:

HOUSING

What is your current housing situation?

Is your current housing situation: Safe ☐ Unsafe ☐ ?

Details:

Do you need help with a housing plan? Yes ☐ No ☐.

Who do you live with? What's your family circumstances? Describe

LEGAL CIRCUMSTANCES

Do you have any upcoming court dates? Yes ☐ No ☐.

If yes, when and where (please attach more information if needed):

Are you court-ordered or asked by an alternative court system to attend treatment? Yes ☐ No ☐.

Are you on probation or parole? Yes ☐ No ☐.

Do you have a conditional sentence? Yes ☐ No ☐. Charges? Yes ☐ No ☐.

If yes to any of the above, please provide contact information on consent form.

FINANCIAL CIRCUMSTANCES

What is your income source during your time at Nimkee?

Income Assistance ___ None _____Other:_____

Have you applied for Income Assistance? Yes ☐ No ☐ I don't know ☐
If yes, application #_____

Do you require assistance with income applications/jobs after completion?

EDUCATIONAL HISTORY

Highest education completed:	
High School	
College	
University	
Trade	
Certificate	

Please attach last final school record, so that we can adequately assess your needs including any reports or assessments if available.

Do you want help with an educational plan upon completion of program Yes ___ No ____
(We will review this again during the program)

TRANSPORTATION ARRANGEMENTS

Travel arrival/return by:		
Car	Bus	Air
Date:	Date:	Date:
Who will arrange:		
Counsellor	Band	Parents:
Date:	Date:	Date:
Do you need help with travel arrangements?	Yes	No
*Note- it is not Nimkee Nupigawagan's expense for travel, except in some emergency situations, as deemed by the Executive Director or Director of Care. We will help to obtain costs for transportation if needed.		

WORKER ATTESTATION:

I have reviewed all the application and filled out with the participant on the following dates:

Date	Initial	Date	Initial
Date	Initial	Date	Initial
Date	Initial	Date	Initial
Comments/Date		Comments/Date	

PRIVACY AND CONSENT

Privacy at Nimkee Nupigawagan

- When you are receiving care from any of the programs or services at Nimkee Nupigawagan Healing Centre (NNHC), personal information needs to be collected from you by counsellors, health care practitioners and other healthcare team members.
- We collect, use and share this information when required or permitted by law; for example, according to the Personal Health Information and Protection Act (PHIPA).
- Sometimes your family, friends, or someone who has the legal right to represent you, may also give us personal information about you.
- We may also need to get personal information from other sources, such as copies of your previous health records from other hospitals or from your family physician, or we may confirm your identity and Ontario Health Card) with the Ministry of Health.

Nimkee Nupigawagan is ethically committed and legally required, to protect your personal information.

We are committed and legally required by *Personal Health and Information and Protection Act (PHIPA)* to protect your privacy. We use and share your information for authorized purposes and must store it securely to protect it. Our staff are trained on how to protect your privacy and to keep your personal information confidential at all times.

Who can look at, use, and share my personal information?

Someone who "**needs to know**" your information in order to provide care and other care-related services, is permitted to look at your personal information (like a counsellor or a nurse). They may use and share it for the following reasons:

- To assist with your ongoing care and services
- To contact you or your family about your medical care when appropriate
- To help us improve the quality of your care and services
- Research (when authorized)
- Teaching and education (of counsellors and nurses, for example)
- To see if you qualify for different benefits or services and to arrange payment.

Your personal information may also be shared with other people with your consent. However, we must provide it without your consent in some circumstances. These include:

- To respond to a court order or subpoena
- To comply with an insurance investigation by another government body eg. insurance
- To report or provide information to investigate a suspicion that a child or an older adult is being abused or neglected
- To report intention of self-harm or harm to another person

If you have any questions or concerns about the limits of confidentiality, you are encouraged to speak with your counsellor, health care provider, or the Executive Director. Our program is committed to being as open as possible about our responsibilities to both you and the community.

CONSENT FOR RELEASE OF INFORMATION

Please indicate below your consent for Nimkee Nupigawagan staff to share your personal information with the following individuals:

SERVICE PROVIDER	NAME	TELEPHONE # (include extensions)	Specify any limitations to the information you consent to share
Probation or Parole Officer			
Lawyer			
Parent			
Other			

CLIENT AUTHORIZATION

I,_____ (full name) have reviewed the information in the Privacy and Consent section (on page 14). I consent to the release of information as specified above (if applicable).

PRINTED NAME _____ SIGNATURE_____

DATE: ____(DD)/_____(MM)/_____(YYYY)

If under the age of 16, parent or guardian signature required:

_____

Parent/Guardian's Signature Date

WITNESS:

PRINTED NAME _____ SIGNATURE_____

RELATIONSHIP_____ DATE: ____(DD)/_____(MM)/_____ (YYYY)

NNHC collects, uses, and shares personal information only in accordance with the *Personal Health Information and Protection Act (PHIPA)*

PARTICIPANT AGREEMENT

I,_____, (full name) have reviewed the referral information and *Client Considerations* section. I agree to voluntarily apply for services with Nimkee Nupigawagan.

I agree while I am in the program I will:

- ☐ treat others with respect and dignity and without discrimination
- ☐ honour the privacy and right to confidentiality of others
- ☐ participate fully in programming and opportunities

I agree to participate in the following activities upon arrival at Nimkee Nupigawagan or produce this in advance:

- ☐ medical assessment with the program doctors and nurses
- ☐ medication review including handing in all medications to the program staff
- ☐ drug testing, if requested
- ☐ review of your personal belongings in your presence
- ☐ program orientation with staff
- ☐ Rapid Antigen Testing/Covid testing, if required

SIGNATURE_____

PRINTED NAME _____ DATE:_____ (DD)/_____(MM)/_____(YYYY)

PARENTS SIGNATURE: _____

PRINTED NAME: _____ DATE: _____(DD)_____(MM) _____(YYYY)

COMMUNITY COUNSELLOR/HEALTH CARE PROFESSIONAL:

SIGNATURE_____

PRINTED NAME _____ DATE: _____(DD)/_____(MM)/_____(Y

QUESTIONS

Nimkee Nupigawagan Healing Centre
Email: info@nimkee.org
519-264-2277 Bridget or Neanna
1-888-685-9862
Hours of Operation: 8:00am-4:00pm, Monday to Friday- Closed during lunch
12-1 pm

Self-Report Medical History Form

Medical History Form

Demographic Information

Last Name		First Name		Middle Init.
Home Address		City		Gender M F
Province & Postal Code		DOB		Health Card #
Emergency		Relationship		Cell:

Medical History

Please check Y (yes) and N (no) for each condition.

	Y	N		Y	N		Y	N		Y	N
Allergies			Bronchitis			Head Injury			High or low Blood Pressure		
Chills			Joint Problems			Seizures			Fever		
Sinusitis			Hemorrhoids			Back Pain			Kidney Stones		
Paralysis			Dizziness			Ear Infections			Excessive Fatigue		
Anemia			Chest Pain			Heart Disease			Chronic Swelling		
Diabetes			Cancer			Tremors			Shortness of breath		
Thyroid			Convulsions			Vomiting			Sexually Transmitted Disease		
Anxiety			Meningitis			Epilepsy			Frequent Urinary Tract Infections		
Eczema			Depression			Chronic Cough			Sickle Cell		
Arthritis			Constipation			Chronic Colds			Diarrhea		
Nausea			Fainting			Pneumonia			Hernia		
Insomnia			Dizziness			Malaria			Heartburn		
Asthma			Nervousness/panic			Appendectomy			Ulcers		

Are you allergic to any foods, medications, or other substances? Yes No If yes, please list:

_____ _____

Participant or Parent Signature Date

*The Medical Form must be completed by the Parent/Participant (Page 1) and the Physical form (Page 2), completed by a doctor or nurse practitioner. Forms may be returned to our office, via: FAX, MAIL,OR HAND DELIVERED. Please use the CONFIDENTIAL disclaimer to return a copy this form, and all other necessary forms. RETURN COMPLETED FORM TO:

Bridget or Neanna
Nimkee Nupigawagan Healing Centre Fax: 519-264-1552
Phone: 1-519-226-2277 or email to: info@nimkee.org

Patient's Full Name:_____ **DOB:**_____ **Today's Date:** _____

Evaluations

Vital Signs			**Laboratory Results and Immunizations Report**		
	Normal	**Abnormal**	Hct_____ Hgb _____	**Normal**	**Abnormal**
Blood Pressure					
Temperature			*Fasting Blood Glucose*		
Pulse			*Urinalysis*		
Weight			**Required Vaccinations**		
Height			*Varicella (Chickenpox)*		
Mood			*Tetanus (Td/Tdap)*		
Recommended Vaccinations ✓ HPV _____ ✓ Covid-19 (Pfizer, Moderna) _____ (client- please attach copy of vaccination)			*MMR*		
			Covid Vaccinations- Lots/Date:		

General Appearance

	Normal	**Abnormal**		**Normal**	**Abnormal**
Skin			*Respiratory*		
Eyes			*Lungs*		
Ears			*Gastrointestinal*		
Nose			*Genitalia*		
Throat			*Lymphatic*		
Cardiovascular B/P			*Extremities*		
Chest			*Neurological*		
Throat/Dental			*Dental*		
Abdomen			*Muscular Skeletal*		

Visual Acuity: *Corrected Vision: Yes____No_____ (Glasses___Contacts__Surgery_____)*

Mental Health Issues: *Y___ N____*

List all known Allergies: _____

Physical Activity Restriction recommended? Yes__No_____:

_____ *List all current medications prescribed:*_____

_____

History of Surgery/Hospitalization: _____

Physician /NP Signature Date License # and or Clinic Stamp