Native Horizons Treatment Centre

INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE INTAKE PROCESS.

If any information is not applicable, indicate as **NA**, unknown as **UNK** and unavailable as **UNA**. Attach a separate sheet of paper if more room is needed.

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED

ADULT INTAKE/REFERRAL VIRTUAL PROGRAM APPLICATION

A. General Information			
Date Application Received by Community Worker:		Date Application Received by Treatment Centre:	
Surname:	First Name:		Nickname or Alias:
Date of Birth:	Age:	Sex:	Provincial Health Card Number:
Address:			Telephone Number:
Language Spoken/Preferred:	Reside On or Off Reserve:		Social Insurance Number:
Status Native/Metis/Non-Status:	Status Number:		Band Name:
Education:	E-mail Address:		Employment Status:
Emergency Contact Name:	Emergency Contact Telephone:		Relationship to Emergency Contact:

Family/Relationships		
Marital Status: ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widowed		
Does client have dependent children?	☐ Yes ☐ No	
If yes, do they have access to adequate childcare while client is participating in the Virtual Program?	☐ Yes ☐ No ☐ Not Applicable	
Are the children in care?	☐ Yes ☐ No ☐ Not Applicable	
Does the client have other dependants?	☐ Yes ☐ No	
Provide information on applicants children or other dependants:		
Name	**Age**	**Relationship**

Family Supports:
Family Strengths:

Legal Status:	
Has client been court ordered to attend a program?	☐ Yes ☐ No
If yes, provide details (include copy of Probation Order):	
Is the client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temporary Absence Order ☐ Charges Pending ☐ Restorative Justice ☐ Probation ☐ Other
Has the client ever been charged with a criminal offence? If yes, please list charge and dates of offences.	

Treatment History:	
Has 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 experience:	

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Reason(s) for currently requesting treatment:

B. Withdrawal Symptoms

Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptom		Describe
Blackouts	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Hallucinations	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Nausea/Vomiting	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Seizures	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Shakes	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Delirium Tremens (DT's)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Ever experienced DT's?	☐ Yes ☐ No	

Has the client experienced problems with any of the following?

Process/Behavioural Addictions		**Describe**
Gambling (slots, cards, bingo, etc.)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No ☐ Not Applicable	

	☐ Unknown	
Sex (promiscuity, pornography, etc.)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Internet/Texting	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

D. Mental Health

Provide the following information about the applicants health status:

Mental Illness		**Describe**
Has client been diagnosed with a mental illness?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Is client currently being treated for any mental health concerns?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, is client taking medication consistently and as prescribed?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Previous suicide attempts?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

If yes, when?		
Hospitalized for suicide attempts?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, when?		
Currently suicidal?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Name of Psychiatrist and/or Psychologist, telephone number and address (if applicable):	Name: Title:	Telephone: Address:

E. Other Issues/Needs	
Does client have cultural and/or spiritual beliefs and practices we should be aware of? If yes, please describe:	☐ Yes ☐ No
Does client have any literacy or learning needs or issues we should be aware of? If yes, please describe:	☐ Yes ☐ No
Are there any other significant issues we should be aware of? If yes, please describe:	☐ Yes ☐ No
Does client understand there is an expectation they have been alcohol and drug free for at least 7 days prior to admission to the Virtual Program?	☐ Yes ☐ No
Please list your personal strengths:	

F. Application Checklist	
Client Authorization	
I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by Native Horizons Treatment Centre.	

Client Signature	**Date:**
Referral Signature	**Date:**

REFERRAL INFORMATION

First Name:	Surname:
Agency:	Title/Position:
Agency Address:	Telephone Number:
Fax Number:	E-mail Address:

Has the client completed four pre-treatment appointments?	☐ Yes ☐ No

Please provide appointment dates:	Date 1:	Date 2:	Date 3:	Date 4:
Please provide session topics for each date:				

Will you continue to see the client once he/she has completed treatment? If no, why not?	☐ Yes ☐ No

What other supports would be available to your client in their community upon completion of the Virtual Program?

Name/Resource	Description of Support

Please provide/attach a brief assessment summary, (Assessment Summaries completed within 6 weeks of this application may be submitted and attached) including summarization of any assessment processes completed with the client (DUSI-R, NWA) which support the application to treatment and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, school, psychological, spiritual, emotional).

Client's Stage of Readiness:

- ☐ Pre-contemplation – Not considering change; resistant to change
- ☐ Contemplation – Unsure of whether or not to change; chronic indecision
- ☐ Determination – Preparation; committed to changing behaviour within one month
- ☐ Action – Begin changing behaviour
- ☐ Maintenance – Behaviour change has persisted for 6 months or more

Please identify concerns you are experiencing.

☐ Child Welfare Involvement	☐ Replacement of Identification	☐ Food Security
☐ Ontario Works Assistance	☐ Report-in to Authorities	☐ Job Security
☐ Disability Assistance	☐ Reliable/Safe Housing	☐ Re-entering the community
☐ Continuing Education	☐ Relocating	☐ Homelessness
☐ Dental Needs	☐ Sexual Health Concerns	☐ Adverse Effects of Medication
☐ Sleep-Wake Disorders	☐ Eating Disorders	
☐ Financial Crisis	☐ Family Court	☐ Other

What areas might need to be addressed in the virtual treatment program?

☐ Low Self-Esteem	☐ Physical Abuse	☐ Inability to Express Emotions
☐ Grief and Loss	☐ Sexual Abuse	☐ Depression
☐ Hatred of Self	☐ Verbal Abuse	☐ Anxiety
☐ Hatred of Others	☐ Emotional Abuse	☐ Sexual Identity
☐ Mistrust of Others	☐ Spiritual Abuse	☐ Criminal Activity
☐ Boundaries	☐ Foster Care/Adoption	☐ Gang Affiliation
☐ Rejection	☐ Residential/Boarding Schools	☐ Anger
☐ Abandonment	☐ Parenting Skills	☐ Mental Health
☐ Suicide	☐ Cultural Oppression	☐ Other

Potential challenges for completing the virtual program:

Referral & Client Checklist

Please initial all applicable items have been completed. Check off any items attached to this application:

Item	Attached	Initials
Psychiatric Evaluations	☐ Yes ☐ No ☐ Not Applicable	
Probation/Court Orders	☐ Yes ☐ No ☐ Not Applicable	
Current Medical Assessment Form	☐ Yes ☐ No	
Assessment Summary (Application)	☐ Yes ☐ No	
Substance Abuse Profile – DUSI-R & Native Wellness Assessment (NWA)	☐ Yes ☐ No	

Please complete tasks before the Virtual Program and initial each item:

Item	Initials
All childcare arrangements have been made while I participate in the Virtual Program	
All medical, dental and optical appointments have been dealt with prior to the Virtual Program	
Client has a device and reliable internet connections to participate in the Virtual Program	

Release of Information			
Having read and understood this form, I hereby authorize Native Horizons Treatment Centre to Release/Request the following information To/From the Person/Agencies listed. In order for this release to be valid, one column must be **check marked and initialed by the client** for each of the following persons/agencies and area of disclosure**: Note: If you have a Referral Worker, you must include them in this form**.			
Persons/Agencies	**Yes**	**No**	**Initials**
1.			
2.			
3.			
Area of Disclosure	**Yes**	**No**	**Initials**
1. Discharge Summary			
2. Continuing Care Plan			
3. Progress Reports			
4. Interview Update Sheet			
5. Other – Specify:			
I understand that any other information will not be released to any other persons without my written consent unless these persons have a court order or are concerned with my medical treatment in an emergency. I also understand that I can withdraw my consent to the release/request of information at any time and that in any event this form will be void ninety (90) days from the date of my signature.			
Client Signature		**Date:**	
Referral Signature		**Date:**	
When, in the opinion of the healthcare provider, the physical and/or mental condition of a client prevents him/her from having the ability to understand the subject matter in respect of which consent is requested and from being able to appreciate the consequences of giving or withholding consent, authorization for disclosure of the information may be given by the client's next of kin.			
Signature of authorized person to sign in lieu of client	**Print Name**		
Relationship to client:	**Date:**		

Native Horizons Treatment Centre

Medical Authorization

130 New Credit Road
Hagersville, ON
N0A-1H0
T: 519-861-4870
Toll Free: 1-877-330-8467
E-mail: intake@nhtc.ca

I understand that by signing this form, Native Horizons Treatment Centre has the right to contact the Physician, if the need to arises. Please note: A qualified medical practitioner is NOT required to complete this form. The client must complete all areas for the Virtual Program.

Applicant Name:	Applicant D.O.B:
Health Card #:	Status (10 digit) or Social Insurance #:

Please indicate where the applicant has experienced any recent (within the past six (6) months) history of the following:

Medical Condition		Describe
Head/Body Lice	☐ Yes ☐ No ☐ Unknown	
Scabies	☐ Yes ☐ No ☐ Unknown	
Impetigo	☐ Yes ☐ No ☐ Unknown	
Rheumatic Fever	☐ Yes ☐ No ☐ Unknown	
Communicable Diseases	☐ Yes ☐ No ☐ Unknown	
Asthma	☐ Yes ☐ No ☐ Unknown	
Sexually Transmitted Diseases	☐ Yes ☐ No ☐ Unknown	

HIV/AIDS	☐ Yes ☐ No ☐ Unknown	
Hepatitis A/B/C	☐ Yes ☐ No ☐ Unknown	
Injectable Drug Use	☐ Yes ☐ No ☐ Unknown	
Cancer	☐ Yes ☐ No ☐ Unknown	
Pregnancy	☐ Yes ☐ No ☐ Unknown	
Diabetes	☐ Yes ☐ No ☐ Unknown	
Food/Other Allergy	☐ Yes ☐ No ☐ Unknown	
Psychiatric and/or Mental Health Involvement	☐ Yes ☐ No ☐ Unknown	
Withdrawal Symptoms (Please provide details of substance use)	☐ None ☐ Moderate ☐ Severe	
COVID-19:	☐ Yes ☐ No ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Unknown	

Note: A T.B. Test is NOT required for the Virtual Program. Client must complete all areas of the form.

Test Type:	**Date:**	**Results:**
T.B. Test		

Chest X-Ray		

Please provide details of all current medication prescribed. If more space is needed, please attach a blank paper to this form.

Medication Name:	Dosage:	Used For Treatment Of:	Initial Date Prescribed:	Prescribed By:

Note: Please refrain from discontinuing medications prior to Virtual Program start date. Ensure that applicant has been stabilized on correct dose before attending the Virtual Program.

Medical Practitioner First Name:	**Last Name:**
Telephone No:	**Address:**
Medical Practitioner Signature:	**Date:**
Applicant Signature:	**Date:**

DUSI-R™
Drug use Screening Inventory-Revised®

Adult Past Year Time Frame **Name:**_____

Ordinarily, how many times each month have you used each of the drugs listed below in the past year?

	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
Alcohol					
1. Beer, Wine, Liquor	○	○	○	○	○
2. Non-Potable Alcohol - Hairspray, Sanitizer, Mouthwash, Aftershave	○	○	○	○	○
Stimulants					
3. Cocaine, Uppers, Khat	○	○	○	○	○
4. Methamphetamine - Crystal Meth	○	○	○	○	○
5. Methamphetamine - Ice/Glass	○	○	○	○	○
6. Methamphetamine - Speed	○	○	○	○	○
Caffeine					
7. Coffee, Tea, Soda/Pop, Energy Drinks, Chocolate	○	○	○	○	○
8. Over the counter Cold Remedies	○	○	○	○	○
9. Over the counter Weight Loss Aids	○	○	○	○	○
Opioids					
10. Prescription Suboxone	○	○	○	○	○
11. Prescription Methadone	○	○	○	○	○
12. Prescription Oxycontin, Oxycodone, Codeine, Morphine	○	○	○	○	○
13. Non-Prescription Oxycontin	○	○	○	○	○
14. Non-Prescription Oxycodone	○	○	○	○	○
15. Non-Prescription Codeine	○	○	○	○	○

DUSI-R™ Drug use Screening Inventory-Revised®

Adult Past Year Time Frame **Name:**_____

16. Non-Prescription Morphine	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
17. Non-Prescription Heroin	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
18. Diverted Methadone	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
19. Diverted Suboxone	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

Sedatives, hypnotics, or anxiolytics

20 Benzodiazepines	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
21. Barbiturates	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
22. Sleeping Medications	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
23. Antianxiety Medications	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
24. Prescribed Sleeping Medications	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
25. Prescribed Antianxiety Medications	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

Hallucinogens (phencyclidine)

26. Phencyclidine - PCP, Angel Dust, Ketamine, Cyclohexamine, Disocilpine	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
27. Other - LSD, Mescaline, MDMA/Ecstacy, DOM/STP, DMT, Magic Mushrooms, Morning Glory Seeds, Jimson Weed, Salvia Divinorum	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

Cannabis

28. Marijuana/Pot/Weed/Hash	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
29. Shatter	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
30. Prescribed Cannabis	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

DUSI-R Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

31. Prescribed CBD	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
32. Synthetic Cannabis - K2, Spice and others	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Inhalants

33. Glue	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
34. Gas/Fuels, Butane Lighters	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
35. Paint, Paint Thinner, Lacquer	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
36. Propane	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
37. Aerosols	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
38. Other Volatile Compounds	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Tobacco

39. Smoking	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
40. Chewing	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
41. Smokeless Tobacco	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Other (or unknown)

42. Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

43. Which drug caused you the most problems? (circle one)

None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/Aftershave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxzone, Benzodiazephines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstacy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer, Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas

DUSI-R™ Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

44. Which drug do you prefer the most? (circle one)	None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/Aftershave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxzone, Benzodiazephines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstacy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer, Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas

Answer ALL of the following questions. Even if a question does not apply exactly, answer according to whether it is MOSTLY YES (TRUE) or MOSTLY NO (FALSE). Answer the questions as they apply to you within the <u>past year</u> and leading up to the present time. If a question does not apply to you, answer NO.

45. *	Have you had a craving or very strong desire for alcohol or drugs?	○ Yes	○ No
46. *	Have you had to use more and more drugs or alcohol to get the effect you want?	○ Yes	○ No
47. *	Have you felt that you could not control your alcohol or drug use?	○ Yes	○ No
48. *	Have you felt that you were "hooked" on alcohol or drugs?	○ Yes	○ No
49. *	Have you missed out on activities because you spend too much money on drugs or alcohol?	○ Yes	○ No
50. *	Did you break rules, miss curfew, or break the law because you were high on alcohol or drugs?	○ Yes	○ No
51. *	Did you change rapidly from very happy to very sad or from very sad to very happy because of drugs?	○ Yes	○ No
52. *	Did you have a car accident after using alcohol or drugs?	○ Yes	○ No
53. *	Have you accidentally hurt yourself or someone else after using alcohol or drugs?	○ Yes	○ No
54. *	Have you had a serious argument or fight with a friend or a family member because of your drinking or drug use?	○ Yes	○ No
55. *	Have you had trouble getting along with any of your friends because of alcohol or drug use?	○ Yes	○ No
56. *	Have you experienced any withdrawal symptoms following use of alcohol or drugs (e.g., headaches, nausea, vomiting, shaking)?	○ Yes	○ No
57. *	Have you had a problem remembering what you had done while you were under the effects of drugs or alcohol?	○ Yes	○ No
58. *	Did you drink large quantities of alcohol when you went to parties?	○ Yes	○ No
59. *	Did you have trouble resisting using alcohol or drugs?	○ Yes	○ No
60. *	Have you ever told a lie in your lifetime?	○ Yes	○ No
61. *	Did you argue a lot?	○ Yes	○ No
62. *	Did you brag a lot?	○ Yes	○ No
63. *	Did you tease or do harmful things to animals?	○ Yes	○ No

DUSI-R™ Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

64. *	Did you yell a lot?	Yes	No
65. *	Have you been stubborn?	Yes	No
66. *	Were you suspicious of other people?	Yes	No
67. *	Did you swear or use dirty language a lot?	Yes	No
68. *	Did you tease others a lot?	Yes	No
69. *	Did you have a bad temper?	Yes	No
70. *	Have you been very shy?	Yes	No
71. *	Did you threaten to hurt people?	Yes	No
72. *	Did you talk louder than most other people?	Yes	No
73. *	Were you easily upset?	Yes	No
74. *	Did you do things a lot without first thinking about the consequences?	Yes	No
75. *	Did you do risky or dangerous things a lot?	Yes	No
76. *	Did you take advantage of people?	Yes	No
77. *	Did you generally feel angry?	Yes	No
78. *	Did you spend most of your free time by yourself?	Yes	No
79. *	Were you a loner?	Yes	No
80. *	Were you very sensitive to criticism?	Yes	No
81. *	In your lifetime, are your table manners better in a restaurant than at home?	Yes	No
82. *	Have you had a physical exam or been under a doctor's care?	Yes	No
83. *	Have you had any accidents or injuries that still bother you?	Yes	No
84. *	Did you either sleep too much or too little?	Yes	No
85. *	Have you either lost or gained more than 10 pounds?	Yes	No
86. *	Did you have less energy than you think you should have?	Yes	No
87. *	Did you have trouble with your breathing or with coughing?	Yes	No
88. *	Did you have any concerns about sex or trouble with your sex organs?	Yes	No
89. *	Have you had sex with someone who shot up drugs?	Yes	No
90. *	Have you had trouble with abdominal pain or nausea?	Yes	No
91. *	Have your eye whites ever turned yellow?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

92. *	In your lifetime, did you ever feel that you wanted to swear?	Yes	No
93. *	Have you intentionally damaged someone else's property?	Yes	No
94. *	Have you stolen things?	Yes	No
95. *	Have you gotten into physical fights?	Yes	No
96. *	Have you been a fidgety person?	Yes	No
97. *	Have you been restless and unable to sit still?	Yes	No
98. *	Did you get frustrated easily?	Yes	No
99. *	Did you have trouble concentrating?	Yes	No
100. *	Did you feel sad a lot?	Yes	No
101.*	Did you bite your fingernails?	Yes	No
102. *	Did you have trouble sleeping?	Yes	No
103. *	Have you been nervous?	Yes	No
104. *	Did you get easily frightened?	Yes	No
105.*	Did you worry a lot?	Yes	No
106. *	Did you have trouble getting your mind off things?	Yes	No
107. *	Did people stare at you?	Yes	No
108. *	Did you hear things that no one else around you heard?	Yes	No
109. *	Did you have special powers nobody else has?	Yes	No
110. *	Were you afraid to be around people?	Yes	No
111. *	Did you often feel like you wanted to cry?	Yes	No
112. *	Did you have so much energy that you did not know what to do with yourself?	Yes	No
113. *	Have you ever felt tempted to steal something in your lifetime?	Yes	No
114. *	Were you disliked by others?	Yes	No
115. *	Were you usually unhappy with how well you did in activities with your friends?	Yes	No
116. *	Was it difficult to make friends in a new group?	Yes	No
117. *	Did people take advantage of you?	Yes	No
118. *	Were you afraid to stand up for your rights?	Yes	No
119. *	Was it hard for you to ask for help from others?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised®

Adult Past Year Time Frame **Name:**_____

120. *	Were you easily influenced by other people?	Yes	No
121. *	Did you prefer doing things with people much older or younger than you?	Yes	No
122. *	Did you worry about how your actions would affect others?	Yes	No
123. *	Did you have difficulty standing up for your opinions?	Yes	No
124. *	Did you have trouble saying "no" to people?	Yes	No
125. *	Did you feel uncomfortable if someone gave you a compliment?	Yes	No
126. *	Did people see you as being unfriendly?	Yes	No
127. *	Did you avoid eye contact when talking to people?	Yes	No
128. *	Has your mood ever changed in your lifetime?	Yes	No
129. *	Has a member of your family (mother, father, brother, or sister) ever used drugs to get high like marijuana, cocaine, or heroin?	Yes	No
130. *	Has a member of your family used alcohol to the point of causing problems at home, work, or with friends?	Yes	No
131. *	Has a member of your family ever been arrested?	Yes	No
132. *	Did you have frequent arguments with your children, parents or spouse which involved yelling and screaming?	Yes	No
133. *	Did your family hardly do things together?	Yes	No
134. *	Were your parents or spouse unaware of your likes and dislikes?	Yes	No
135. *	Were there no clear rules about what you can and cannot do?	Yes	No
136. *	Were your parents or spouse unaware of what you really think or feel about things that are important to you?	Yes	No
137. *	Did you argue with your parents or your spouse or other family members a lot?	Yes	No
138. *	Were your parents or your spouse often unaware of where you were and what you were doing?	Yes	No
139. *	Were your parents or your spouse away from home most of the time?	Yes	No
140. *	Did you feel that either your parents or your spouse don't care about you?	Yes	No
141. *	Were you unhappy about your living arrangements?	Yes	No
142. *	Did you feel in danger at home?	Yes	No
143. *	In your lifetime, did you ever get angry?	Yes	No
144. *	Did you dislike school?	Yes	No
145. *	Did you have trouble concentrating in school or when studying?	Yes	No
146. *	Were your grades below average?	Yes	No

DUSI-R Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

147. *	Did you cut/skip school more than two days a month?	Yes	No
148. *	Were you absent from school a lot?	Yes	No
149. *	Have you thought seriously about quitting school?	Yes	No
150. *	Did you often not do your school assignments?	Yes	No
151. *	Did you often feel sleepy in class?	Yes	No
152. *	Were you often late for class?	Yes	No
153. *	Did you have different friends at school this year than you did last year?	Yes	No
154. *	Did you feel irritable and upset when in school?	Yes	No
155. *	Were you bored in school?	Yes	No
156. *	Were your grades in school worse than they used to be?	Yes	No
157. *	Did you feel in danger at school?	Yes	No
158. *	Have you failed a grade in school?	Yes	No
159. *	Did you feel unwelcome in school clubs or extracurricular activities?	Yes	No
160. *	Have you missed or been late to school because of alcohol or drugs?	Yes	No
161. *	Have you been in trouble at school because of alcohol or drugs?	Yes	No
162. *	Have alcohol or drugs interfered with your homework or school assignments?	Yes	No
163. *	Have you been suspended?	Yes	No
164. *	In your lifetime, did you ever put things off that you needed to do?	Yes	No
165. *	Have you had a paying job that you were fired from?	Yes	No
166. *	Have you stopped working at a job because you just didn't care?	Yes	No
167. *	Did you need help from others to go about finding a job?	Yes	No
168. *	Have you been frequently absent or late for work?	Yes	No
169. *	Did you find it difficult to complete work tasks?	Yes	No
170. *	Have you made money doing something that was against the law?	Yes	No
171. *	Have you used alcohol or drugs while working on a job?	Yes	No
172. *	Have you been fired from a job because of drugs?	Yes	No
173. *	Did you have trouble getting along with bosses?	Yes	No
174. *	Did you mostly work so that you can get money to buy drugs?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

175. *	In your lifetime, are you more happy if you win than lose a game?	Yes	No
176. *	Did any of your friends regularly use alcohol or drugs?	Yes	No
177. *	Did any of your friends sell or give drugs away?	Yes	No
178. *	Did any of your friends lie a lot?	Yes	No
179. *	Did your parents or spouse dislike your friends?	Yes	No
180. *	Have any of your friends been in trouble with the law?	Yes	No
181. *	Were most of your friends older than you?	Yes	No
182. *	Did your friends cut school or work a lot?	Yes	No
183. *	Did your friends get bored at parties when there was no alcohol served?	Yes	No
184. *	Have your friends brought drugs to parties?	Yes	No
185. *	Have your friends stolen anything from a store or damaged property on purpose?	Yes	No
186. *	Did you belong to a gang?	Yes	No
187. *	Were you bothered by problems you were having with a friend?	Yes	No
188. *	Was there no friend to confide in?	Yes	No
189. *	Compared to most people, did you have few friends?	Yes	No
190. *	Have you ever in your lifetime been talked into doing something you didn't want to do?	Yes	No
191. *	Compared to most people, did you do less sports?	Yes	No
192. *	Did you usually stay out late on nights when you had to go to school or work the next morning?	Yes	No
193. *	On a typical day, do you watch more than two hours of TV?	Yes	No
194. *	Did you go to bars with your friends on a regular basis - at least twice a week, or were the parents absent at most of the parties you went to?	Yes	No
195. *	Did you exercise less than most people you know?	Yes	No
196. *	Was your free time spent just hanging out with friends?	Yes	No
197. *	Were you bored most of the time?	Yes	No
198. *	Did you do most of your recreation or leisure activities alone?	Yes	No
199. *	Did you use alcohol or drugs for recreational reasons?	Yes	No
200. *	Compared to most people, were you less involved in hobbies or outside interests?	Yes	No
201. *	Were you dissatisfied with how you spend your free time?	Yes	No
202. *	Did you get tired very quickly when you exerted yourself?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised®

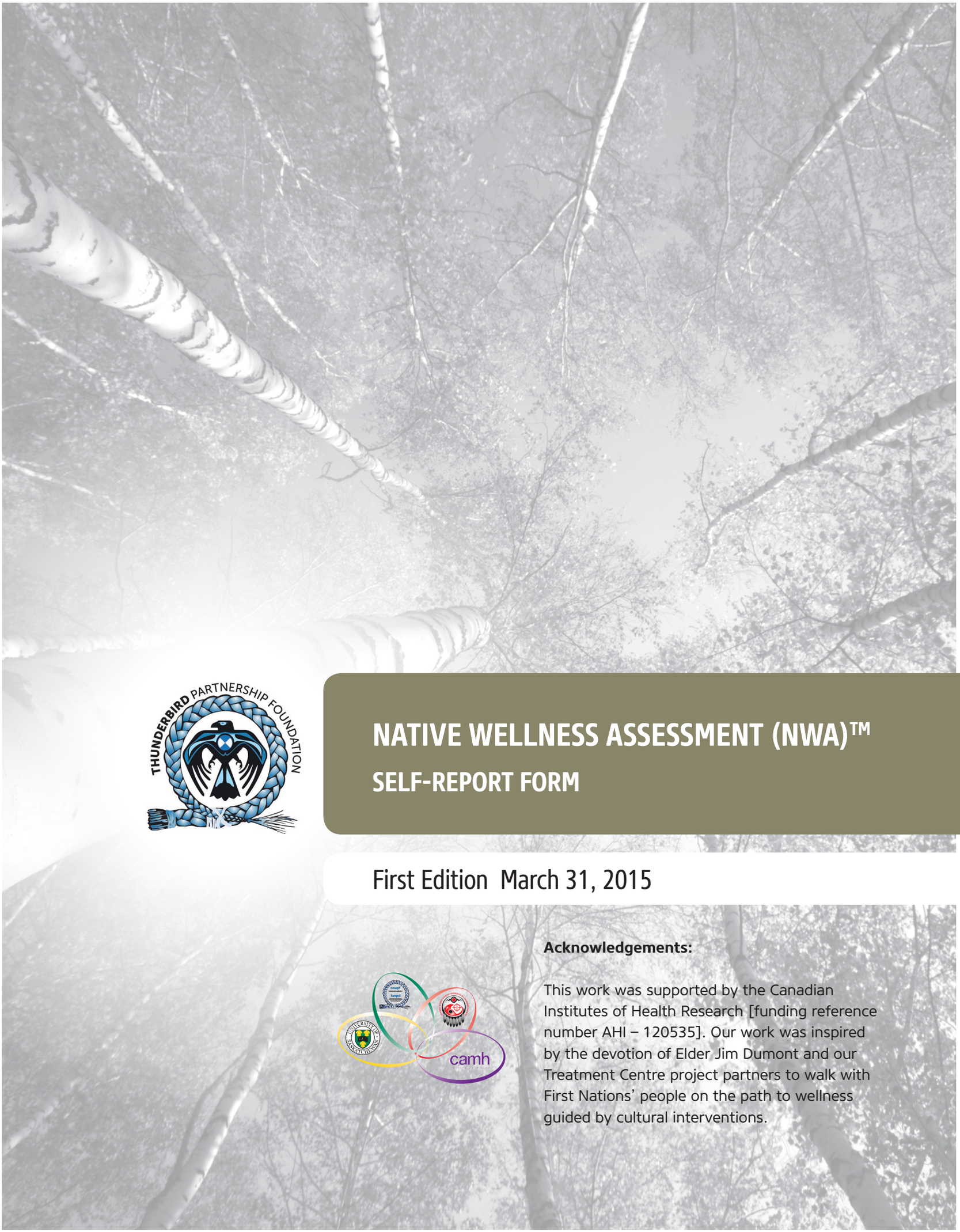
Adult Past Year Time Frame **Name:**_____

203. *	Have you ever bought anything in your lifetime that you did not need?	○ Yes ○ No
204. *	Have you felt your cultural identity doesn't matter?	○ Yes ○ No
205. *	Have you had frequent nightmares?	○ Yes ○ No
206. *	Have you felt helpless to change your life?	○ Yes ○ No
207. *	Have you experienced frequent emotions like fear, anger, guilt, or shame?	○ Yes ○ No
208. *	Have you frequently thought about ending your life?	○ Yes ○ No
209. *	Have you felt alienated from family, friends, or community?	○ Yes ○ No
210. *	Have you harmed yourself (cutting, scratching, etc.)?	○ Yes ○ No
211. *	Have you felt guilty about experiencing pleasant emotions?	○ Yes ○ No
212. *	Have you felt overwhelmed by upsetting memories?	○ Yes ○ No
213. *	Have you felt betrayed by others?	○ Yes ○ No
214. *	Have you lacked motivation to care for your health (diabetes, heart, diet, exercise, hygiene)?	○ Yes ○ No

OFFICE USE ONLY

Date of Completion _____

NOTES:



NATIVE WELLNESS ASSESSMENT (NWA)™

SELF-REPORT FORM

First Edition March 31, 2015

Acknowledgements:

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Native Wellness Assessment (NWA-S)
(Self-Report Form)

Please complete this survey designed to assess your **Native wellness**. Once you have filled out the background section used for research, please complete the three sections concerning a rating of statements and cultural interventions/activities. You may provide any additional comments at the end of the survey if you like.

The survey answers must be entered on the web at the following address ***www.thunderbirdpf.org*** in order to receive the client report which provides the analysis and interpretation of results.

To be completed by Substance Use/Mental Health Service Staff prior to the client completing the survey:

Client ID: _____ *(number as used in Substance Use/Mental Health Service)*

Date of Assessment: _____ *(dd/mm/yyyy)*

Completion: ○ 1st time completed ○ 2nd time completed ○ 3rd time completed by client

Point in time:
○ Entry to program (administered within 7 days of intake)
○ In-Progress (administered halfway through program)
○ Exit from program (administered within the last 7 days of the program)

Substance Use/Mental Health Service : _____
Length of Program: _____ weeks

Background:

Your responses in this section will be grouped with that of others to make sure the survey is statistically valid. The information you provide here will not be used to identify you specifically under any circumstances.

Gender: ○ Female ○ Male ○ Other(Ie: Two-Spirited/LGBTQ/Gender fluid) _____

Age: _____ years

Ethnicity:
○ **First Nations**
If Yes, which Nation _____ **OR** ○ Don't Know

○ **Métis**
If Yes, which First Nation connection _____ **OR** ○ Don't Know

○ **Inuit**

○ **Other** _____

What is your FIRST Language? _____

If applicable, what is your SECOND Language? _____

If applicable, what is your THIRD Language? _____

How many times have you sought help for issues related to substance use/mental health prior to the service you are at now?

_____ time(s)

Please provide the name(s) of the prior Substance Use/Mental Health Service (s):

1. Program Name: _____ Number of times: _____
2. Program Name: _____ Number of times: _____
3. Program Name: _____ Number of times: _____
4. Program Name: _____ Number of times: _____
5. Program Name: _____ Number of times: _____
6. Program Name: _____ Number of times: _____

Instructions:

Please rate the following statements based on your own feelings and thinking. As this survey is not a test that you can pass or fail, there is no right or wrong way to answer any of the statements. Your first thought or impression is usually the best.

The following example will explain how to proceed. Please read the example statement. If you *mostly agree* with the example statement, draw a circle around the number 3 that corresponds with this.

Please use a dark black pen to complete the form. Please use the 'Don't Know' (DK) option sparingly and **ONLY** if you feel you are not able to respond to the statement within a range of 'Disagree' to 'Strongly Agree'.

	DK Don't Know	**0** Do Not Agree	**1** Agree a LIttle	**2** Kind of Agree	**3** Mostly Agree	**4** Strongly Agree
The eagle is an important symbol in our culture.	DK	0	1	2	(3)	4

How to change an answer:

If you do need to change your answer, please draw an 'X' through your original circle and then draw another circle over the new number you have selected as follows:

	DK Don't Know	**0** Do Not Agree	**1** Agree a LIttle	**2** Kind of Agree	**3** Mostly Agree	**4** Strongly Agree
The eagle is an important symbol in our culture.	DK	0	1	2	~~3~~	(4)

Statements: Section 1

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
1	I can see my loved ones who have gone on, or ancestors, in dreams or ceremony.	DK	0	1	2	3	4
2	My Native culture fuels my desire to live a good life.	DK	0	1	2	3	4
3	I believe that the Creator is the source of all life.	DK	0	1	2	3	4
4	My relationship to the land I come from is important.	DK	0	1	2	3	4
5	I feel comforted when I participate in cultural activities and ceremonies.	DK	0	1	2	3	4
6	I feel a need to connect with my spirit.	DK	0	1	2	3	4
7	My Native language is a sacred language.	DK	0	1	2	3	4
8	Knowing the names in the generations of my family is important for my identity.	DK	0	1	2	3	4
9	All living things have a spirit.	DK	0	1	2	3	4
10	Ceremonies and cultural activities open me up to share my thoughts and feelings with others.	DK	0	1	2	3	4
11	I learn about the Creator's teaching to live a good life.	DK	0	1	2	3	4
12	I am known in Creation through my traditional name or clan family.	DK	0	1	2	3	4
13	The Creator made a way for me to live a good life.	DK	0	1	2	3	4
14	The more I learn about my culture, the more confident I feel about my life.	DK	0	1	2	3	4
15	The more I learn about the importance of my spirit the more I want a good life.	DK	0	1	2	3	4

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
16	I see my role in caring for water and fire as important for a balanced life.	DK	0	1	2	3	4
17	I believe there is a reason the Creator gave me life.	DK	0	1	2	3	4
18	The Creator gives me my Native identity.	DK	0	1	2	3	4
19	I connect to life by being on the land and learning the names and stories of plants and animals.	DK	0	1	2	3	4
20	I want to be like my ancestors who worked to have a good life.	DK	0	1	2	3	4
21	I need to pay attention to my spirit because it is important to my physical well-being.	DK	0	1	2	3	4
22	My connection to Mother Earth makes the land I come from my home.	DK	0	1	2	3	4

Interventions 1: How would you describe your connection during each of the following interventions lately?

		DP Did Not Practice	1 Weak	2 Moderate	3 Strong
1	Smudging	DP	0	1	2
2	Prayer	DP	0	1	2
3	Sweat lodge ceremony	DP	0	1	2
4	Talking / sharing circle	DP	0	1	2
5	Nature walks	DP	0	1	2
6	Meaning of prayer	DP	0	1	2
7	Use of drum / pipe / shaker	DP	0	1	2
8	Sacred medicines	DP	0	1	2
9	Use of natural foods	DP	0	1	2
10	Ceremony preparation	DP	0	1	2
11	Cultural songs	DP	0	1	2

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
23	I seek understanding of my purpose in life through cultural knowledge.	DK	0	1	2	3	4
24	I give thanks for what I receive from Creation.	DK	0	1	2	3	4
25	My language and a connection to the land help me to know who I am.	DK	0	1	2	3	4
26	The respect I feel for my relatives in Creation, makes me want to give something back.	DK	0	1	2	3	4
27	The Creation story is important to me because it helps me to feel my life is meaningful.	DK	0	1	2	3	4
28	My dreams help guide and direct me through my life.	DK	0	1	2	3	4
29	The Creation story that I believe in is Native in origin.	DK	0	1	2	3	4
30	I make offerings such as food and other gifts to my ancestors because they help me.	DK	0	1	2	3	4
31	I listen to traditional teachings to learn how my ancestors understood and lived life.	DK	0	1	2	3	4
32	Laughter heals me.	DK	0	1	2	3	4
33	I need to learn more about my Native identity.	DK	0	1	2	3	4
34	I respect sacred bundle items.	DK	0	1	2	3	4
35	I understand how the Creator helps me.	DK	0	1	2	3	4
36	I treat my body as sacred.	DK	0	1	2	3	4
37	My identity as a Native person helps me to know who I am and what to do in life.	DK	0	1	2	3	4
38	I know who my extended or adopted family is.	DK	0	1	2	3	4

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
39	It is important to me that I learn, speak and understand my Native language.	DK	0	1	2	3	4
40	The Creator gives me choices in how to live my life.	DK	0	1	2	3	4
41	My Native language comes from the Creator.	DK	0	1	2	3	4
42	I have a necessary role in my family.	DK	0	1	2	3	4
43	Understanding my spirit connection to all life helps me to be well.	DK	0	1	2	3	4
44	I gather traditional foods because they are important for my health.	DK	0	1	2	3	4

Interventions 2: How would you describe your connection during each of the following interventions lately?

		DP Did Not Practice	1 Weak	2 Moderate	3 Strong
12	Fishing / Hunting	DP	0	1	2
13	Spiritual teachings	DP	0	1	2
14	Water as healing	DP	0	1	2
15	Use of sacred medicines	DP	0	1	2
16	Community cultural activities	DP	0	1	2
17	Fire as healing	DP	0	1	2
18	Storytelling	DP	0	1	2
19	Culture-based art	DP	0	1	2
20	Pipe ceremony	DP	0	1	2
21	Sacred places	DP	0	1	2
22	Use of native language	DP	0	1	2
23	Creation story	DP	0	1	2
24	Cultural dances / pow wow	DP	0	1	2
25	Receiving help from traditional Healer / Elder	DP	0	1	2
26	Gardening, harvesting	DP	0	1	2
27	Giveaway ceremony	DP	0	1	2

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
45	I strengthen my connection by talking to the Creator.	DK	0	1	2	3	4
46	My family gives me strong identity.	DK	0	1	2	3	4
47	I know all of Creation has spirit caring for me.	DK	0	1	2	3	4
48	I take initiative to be physically active through land based activities.	DK	0	1	2	3	4
49	I need to have a connection with my ancestors.	DK	0	1	2	3	4
50	I feel all of Creation is my family.	DK	0	1	2	3	4
51	I feel the spirit is with me when I am on the land, in ceremony, or through my dreams.	DK	0	1	2	3	4
52	I use cultural ways such as ceremonies, food and medicine for cleansing and healing.	DK	0	1	2	3	4
53	How I dress shows pride in my culture.	DK	0	1	2	3	4
54	I feel a connection between my community history and my own story.	DK	0	1	2	3	4
55	I think my spirit lives forever.	DK	0	1	2	3	4
56	I show who I am as a Native person through the things I wear.	DK	0	1	2	3	4
57	The Creator gave me a good mind.	DK	0	1	2	3	4
58	I see the strengths Native people have as a community.	DK	0	1	2	3	4
59	I think about the whole of Creation - the universe, all nature, plants, animals, and all people - as my family.	DK	0	1	2	3	4
60	I go to Elders to learn about our Native ways.	DK	0	1	2	3	4

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
61	I recognize that I can contribute to my community.	DK	0	1	2	3	4
62	I understand my inner knowing is my spirit guiding me through life.	DK	0	1	2	3	4
63	I give back to Creation as a way of showing my thankfulness.	DK	0	1	2	3	4
64	I feel confident getting support from my community.	DK	0	1	2	3	4
65	It is up to me to ensure balance in every part of my life.	DK	0	1	2	3	4
66	I participate in traditional ways of sharing.	DK	0	1	2	3	4

Interventions 3: How would you describe your connection during each of the following interventions lately?

		DP Did Not Practice	1 Weak	2 Moderate	3 Strong
28	Shaker / hand drum making	DP	0	1	2
29	Naming ceremony	DP	0	1	2
30	Water bath	DP	0	1	2
31	Blanketing / welcoming ceremony	DP	0	1	2
32	Cultural events / marches	DP	0	1	2
33	Dream interpretation	DP	0	1	2
34	Land-based / cultural camp	DP	0	1	2
35	Ghost / memorial feast	DP	0	1	2
36	Hide making / tanning	DP	0	1	2
37	Fasting	DP	0	1	2
38	Horse program	DP	0	1	2
39	Other taught / participated in / experienced	DP	0	1	2
	Other (name):				

67	Do you have any other comments you would like to share in relation to the above?

Thank you for your participation!

About the Native Wellness Assessment™:

The Native Wellness Assessment™(NWA™) was launched on June 25, 2015 and is the first of its kind in the world. Statistically and psychometrically, the NWA™ content and structure performed well, demonstrating that culture is an effective and fair intervention for Indigenous Peoples with addictions. The NWA™ can inform Indigenous health and community-based programs and policy. The NWA™ is a product of the Honouring Our Strengths: Indigenous Culture as Intervention in Addictions Treatment (CasI) research project whose team included Indigenous and non-Indigenous researchers from across Canada, Elders, Indigenous knowledge keepers, cultural practitioners, service providers, and decision makers. To learn more about the validation of the NWA™ visit: http://nnapf.com/nnapf-document-library/

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