

# CHOPRA ADDICTION & WELLNESS CENTER

## STEP 1 - Guest Intake Application Form

Your application will be reviewed by our clinical staff and you can expect us to contact you within 24 - 48hrs; to discuss a possible intake. A non- refundable payment of \$250 is required to process your application. Your \$250 payment is deducted from any subsequent costs at the Center.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Prov/State: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have a Canadian health card number?  Yes  No

If Yes, please provide your personal health number (PHN #) here: \_\_\_\_\_

DOB: \_\_\_\_\_ (MM/DD/YYYY) Age: \_\_\_\_\_ Sex: M / F

Do you have a family physician?  Yes  No

Family Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_

Okay to speak to another member of household :  Yes  No

Okay to leave message:  Yes  No

Let us know how you heard about us:

<input type="checkbox"/> Google	<input type="checkbox"/> Bing	<input type="checkbox"/> Yahoo
<input type="checkbox"/> Facebook	<input type="checkbox"/> Twitter	<input type="checkbox"/> Newsletter
<input type="checkbox"/> Conferences	<input type="checkbox"/> Friend	<input type="checkbox"/> Magazine
<input type="checkbox"/> Chopra.com	<input type="checkbox"/> Other: _____	

# CHOPRA ADDICTION & WELLNESS CENTER

## STEP 2 - Guest Intake Application Form

1. My reasons for wanting to come to the center now:

---

---

---

2. Are you suffering from any health problems or medical illness?  Yes  No

If yes please give details (If necessary including medical information from your Health Care Provider):

---

---

---

3. Have you ever been diagnosed with a communicable disease, HIV, Hepatitis, TB?  Yes  No

If yes please give details:

---

---

4. Are you taking any medications or supplements?  Yes  No

If yes, please provide details as outlined below:

Medication Name	Dose (mg)	Qty (e.g. x 2)	Time of Day Taken	PRN (only as needed)	Why Taken

List additional medications or supplements here: \_\_\_\_\_

---

---

# CHOPRA ADDICTION & WELLNESS CENTER

5. List any allergies you have, including Food and Medications:

---

---

6. Are you suffering from emotional or psychological problems?

Yes  No

If yes, please describe:

---

---

---

---

7. Please indicate on the scale below from 1 to 10, how you are feeling Socially

1 – isolated, no support

10 - supported, no conflicts

1    2    3    4    5    6    7    8    9    10

8. Please indicate on the scale below from 1 to 10, how you are feeling in the area of Spirituality

1 – having no direction, feeling lost

10 – feeling peaceful, having purpose and meaning to life

1    2    3    4    5    6    7    8    9    10

10. Any History of suicide?

Yes  No

If yes, please check when:

within 3 months

past year

more than one year ago

**History of self-mutilation/self harm**

Yes  No

If yes, please provide details):

---

---

---

**History of Violence?**

Yes  No

If yes, please provide details):

---

---

---

# CHOPRA ADDICTION & WELLNESS CENTER

## 11. Substance Use History

Please indicate all drugs you have used in the past 3 months

- |                                       |  |  |   |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> Alcohol      | <input type="checkbox"/> Heroin        | <input type="checkbox"/> Illicit Methadone | <input type="checkbox"/> Opiates            |
| <input type="checkbox"/> Oxycontin    | <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> Cannabis          | <input type="checkbox"/> Benzodiazepine     |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Barbiturates  | <input type="checkbox"/> Hallucinogen      | <input type="checkbox"/> Prescription Drugs |
| <input type="checkbox"/> Other: _____ |  |  |   |
- No history of abuse    Active abuse    Reduced use    Abstinent    I.V. drug use history

If in *active* abuse, please indicate substance(s) used, frequency, & quantity used in the past two weeks:

---

---

---

## 12. Treatment History

Type of Facility	When & Duration
<input type="checkbox"/> Residential	_____
<input type="checkbox"/> Outpatient Counselling	_____
<input type="checkbox"/> Detox	_____
<input type="checkbox"/> Outpatient Methadone	_____
<input type="checkbox"/> 12 Steps	_____
<input type="checkbox"/> Stopped on Own	_____
<input type="checkbox"/> Other	_____

## 13. When would you like to come?

- Within 3 days    1 week    other \_\_\_\_\_

## 14. Which program are you interested in?

- 6 week program    28 day program    14 day program    other \_\_\_\_\_

15. Do you have safe accommodation arranged and available after you leave the center, or should you suddenly need to discontinue services?    Yes    No

## 16. What questions / concerns do you have for us? What else would you like us to know at this time?

---

---

---

# CHOPRA ADDICTION & WELLNESS CENTER

## STEP 3 - Guest Requirements Checklist

While we recognize it is your responsibility to become familiar with our services, we have described a few aspects below. We encourage you to visit our website, read our publications, and ask questions through email, or by phoning us. **We require you to acknowledge your awareness and acceptance of these conditions of the center by checking off on all points and signing your name at the bottom of this form.**

- Be a minimum of 19yrs old
- Want change for yourself, and be accessing the Center by choice
- Have safe and stable housing available
- We offer **some detox** services at our Center. As part of our assessment and to ensure our services accurately match your physical condition, a urine drug screening test **will be** administered the day you arrive. You may be temporarily denied services at our center if you are suffering from severe physical withdrawal symptoms upon arrival. Please consult our Center nurse if you have questions.
- This is a facility committed to supporting wellness, and we require no smoking while you are a resident. We have [smoking cessation programming](#) available!
- We have a delicious **vegetarian only** menu. We believe a balanced vegetarian diet is an optimal nutritional plan for the wellness center.
- This is a therapeutic center with emphasis on group-work. We also provide twice weekly 50 mins individual sessions. Your intent and ability to participate in scheduled sessions are a key component for your success and the success of other residents.
- I understand that sessions may involve yoga and physical activity. I agree to participate only within the range of my physical comfort.
- You are responsible for payment of services. If you are seeking payment from other sources of funding (e.g. insurance services) the Center will share appropriate information only with your consent.
- No residents' vehicles may be parked at Chopra Addiction & Wellness Center. Transportation can be arranged from Vancouver or from the town of Squamish, British Columbia.
- To ensure guest safety, you are required to remain on the grounds of the Center at all times unless specific support from a staff member is given.
- We require you to abstain from alcohol and non-prescribed drugs at the Center . Only decaffeinated beverages with natural sweeteners (i.e. honey) are permitted at the Center.
- I understand the focus of my work at the centre is about my emotional wellbeing.
- I understand I will be assigned a room upon arrival and this will be a shared space.
- If I come to the Center with prescription medications, I will take them as prescribed by my family physician. If I want to reduce any medications, I will work with the center medical team and follow their recommendations on reduction or tapering protocols. Depending on my length of stay and safety reasons, the Center is not able to guarantee that I will be off all medications.
- I have no criminal history, no charges pending nor am I on parole or probation.
- Upon arrival at the Center we require you to sign an agreement: 1) acknowledging your commitment to keep confidential all information re. other guests accessing service at Chopra Addiction & Wellness Center, and; 2) acknowledging staff at the Center work as a team and routinely share information with each other in order to best support your wellness.
- Our intake staff will call contact you if there is additional information required to confirm your intake. Please fax the required information to 604-892-3003 or email us at [info@chopratreatmentcenter.com](mailto:info@chopratreatmentcenter.com)

Signature confirming acceptance of all conditions noted above: \_\_\_\_\_

# CHOPRA ADDICTION & WELLNESS CENTER

## STEP 4 - Payment Details for Deposit

### Payment details for \$250.00 Application Fee:

Type of Card: \_\_\_\_\_ (Visa or MasterCard) Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVV: \_\_\_\_\_

### Billing Address:

Is your billing address the same as your current address?

- Yes, same as my address provided in Step 1
- No, different address

If you have a different billing address to the one provided in Step 1, please provide details below:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Prov/State: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_