Personal Information

Name:	
Street Address:	
City:	Postal Code:
Phone (home):	Cell: Work:
Email Address:	
Gender *(click)*: M ☐ F ☐	Date of Birth:
Health Card Number:	
Type of Referral: ☐ Self-Referred ☐ Physician Referred ☐ Community Referral	
How did you hear about OTR? *(click)*	☐ Family Doctor ☐ Specialist ☐ Friend/Family ☐ Community Agency ☐ Website ☐ Facebook ☐ Other:

Substance Use History

Substance	Level of Concern			Date of last use?	Route of use
	Low	Medium	High		
Alcohol	☐	☐	☐		
Marijuana/Hash	☐	☐	☐		
Cocaine/Crack	☐	☐	☐		
Opioids (Heroin, Morphine, Fentanyl, etc.)	☐	☐	☐		
Benzodiazepines (Valium, Ativan, Xanax etc.)	☐	☐	☐		
Club drugs (Ecstasy, Ketamine, GHB etc.)	☐	☐	☐		
Hallucinogens (Mushrooms, LSD, Salvia, etc.)	☐	☐	☐		
Amphetamines (Crystal meth, Dexedrine, Ritalin, etc.)	☐	☐	☐		
Tobacco/E-cigarettes	☐	☐	☐		
Other Drugs (specify)	☐	☐	☐		