



WOLFE Family Wellness

Working Open-heartedly, Leading Families to Empowerment

Participant Guidelines to WOLFE Family Wellness:

1. This program is completely voluntary to attend and complete. Participants can leave the program at any time to be discharged with no reimbursement.
2. Must be willing to participate in all cultural activities and ceremonies
3. Adult participants must complete detox before beginning programming at WOLFE
5. All travel arrangements must be prearranged; WOLFE does not provide transportation to attend nor upon completion of treatment.
6. Random drug tests will be carried out throughout the program to ensure sobriety
7. Parents/Caregivers are expected to provide the day-to-day care of their children, with staff providing support as necessary.
8. Any drug/alcohol use will not be accepted at WOLFE Family Wellness

Referral Agent:

Referral's Name: _____

Referral Organization: _____

Job Title: _____

Telephone Number: _____

Fax: _____

Email Address: _____

Referral Signature: _____

Date: _____

If participants are non-status, please indicate the person(s)/agency that will be covering costs:

Reason for referral:

Family Strengths: Please identify family strengths (ex. willingness to change, open communication, spirituality, accessing resources, etc.):

Family Goals: Please any intended goals the family would like to achieve as a family unit.

Upon completion of WOLFE: What will the referring worker involvement be with the participant/s?

Children Services: Is there any current involvement with Children Services, if so please state the type of order/legal status

Please go through the referral package with applicants to ensure they are aware of all program requirements and that the information provided is correct.

INTAKE – Participating Family Information

Adult 1: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

First Nation: _____

Adult 2: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

First Nation: _____

Child 1: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 2: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 3: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 4: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 5: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Child 6: Male Female Non-Binary

First Name: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Status: Yes No Treaty Number (10 digit): _____

Alberta Health Care Number: _____

Telephone Number: _____

Legal Guardian: _____

First Nation: _____

Do applicants live on reserve? Yes No

Do the applicants and/or children currently practice any cultural traditions ? Yes No

If yes, please provide examples.

Do the applicants have any specific cultural teachings they would be interested in participating in? Yes No

If Yes, please provide examples

MARITAL INFORMATION IF APPLICABLE

1. How long has the participants been involved in the present marital relationship?

2. Indicate the strengths holding the relationship together and the weaknesses that are causing problems.

Marital Strengths?

Marital Weaknesses?

3. Relationship Breakdown? i.e. Drugs, alcohol, domestic violence, etc.

4. What event(s) took place that caused the participant to seek help at this time?

Include details surrounding the event(s).

PARTICIPANT'S PERSPECTIVE/PERCEPTION OF THE PROBLEM – This section is to be completed by the applicant/s

1. Does the participant feel they have a co-dependency problem? Yes No

If yes, explain

2. Are Indigenous cultures and values significant for participants' change? Yes No
3. Was the participant raised by biological parents? Yes No
4. Were there alcohol or drug problems in the family of origin while the participant was growing up (ie. Parents, guardian, sibling)? Yes No If yes, explain

5. Major areas affected by substance use (such as employment, friends, and relationships with children). Give details

6. Has the participant previously attended substance abuse programs? Yes No If yes, provide details, name of the program; date attended; length of intervention; was program completed

7. What has brought you to the decision to apply for programming at WOLFE at this time:

8. Currently, what substance are you seeking treatment for?

9. How long have you struggled with substances?

10. Identify goals you would like to achieve upon completing programming at WOLFE?

11. Please identify all supports: family, friends, professionals, and organizations

Name	Relationship	Telephone Number

See next page for child information.

Child Behaviour Awareness:

Child 1 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to Animals			
Fire Setting			
Bed wetting			
Inappropriate Sexual Behaviours			
Suicidal Ideations/attempts			
Self-Harm			
Chronic School absences			
Mental Health Diagnosis			
Daily Medication			
Allergies			
Additional Information to be shared			

Child 2 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to Animals			
Fire Setting			
Bed wetting			
Inappropriate Sexual Behaviours			
Suicidal Ideations/attempts			
Self-Harm			
Chronic School absences			
Mental Health Diagnosis			
Daily Medication			
Allergies			
Additional Information to be shared			

Child 3 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to Animals			
Fire Setting			
Bed wetting			
Inappropriate Sexual Behaviours			
Suicidal Ideations/attempts			
Self-Harm			
Chronic School absences			
Mental Health Diagnosis			
Daily Medication			
Allergies			
Additional Information to be shared			

Child 4 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to Animals			
Fire Setting			
Bed wetting			
Inappropriate Sexual Behaviours			
Suicidal Ideations/attempts			
Self-Harm			
Chronic School absences			
Mental Health Diagnosis			
Daily Medication			
Allergies			
Additional Information to be shared			

Child 5 Name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to Animals			
Fire Setting			
Bed wetting			
Inappropriate Sexual Behaviours			
Suicidal Ideations/attempts			
Self-Harm			
Chronic School absences			
Mental Health Diagnosis			
Daily Medication			
Allergies			
Additional Information to be shared			

Child 6 name:

Behaviour	YES	NO	Describe
Aggression towards others or self			
Violent outburst			
Challenges with authority			
Cruelty to Animals			
Fire Setting			
Bed wetting			
Inappropriate Sexual Behaviours			
Suicidal Ideations/attempts			
Self-Harm			
Chronic School absences			
Mental Health Diagnosis			
Daily Medication			
Allergies			
Additional Information to be shared			



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MEDICAL ASSESSEMENT

The medical assessment has to be completed by Doctor/Registered Nurse for each family member.

To the Registered Nurse/Doctor:

The aforementioned individual will undergo a medical evaluation as a potential participant in our 90-day residential program for substance use or abuse. Our program is made to help those who admit that their usage or misuse has hampered their ability to work effectively and who are physically and mentally prepared to take part in a rigorous program at WOLFE Family Wellness. The participant listed below should be free of any health issues that would limit their ability to take part in the program.

Participant Personal Information:

Date of Assessment:

First Name: _____ Last Name: _____

Birthday (MM/DD/YYYY): _____ Age: _____

Gender: Male Female Non-Binary

Alberta Health Care Number: _____

Treaty Number: _____

Please indicate any medical illnesses or diagnoses:

Are there any current or recent medical problems which may or may not require follow-up while the participant is in treatment? Yes: ____ No: ____

If yes, please explain:

Please list all current medications for the participant: Name of Medication/
Indication/Duration:

Name of Doctor/RN: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Telephone: _____

Fax: _____

OFFICE STAMP
