INTAKE FORM

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A. DEMOGRAPHIC INFORMATION

Title: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Last Name: **First Name(s):** **Middle Name:**

Language(s) Spoken: English ☐ French ☐ Other(s) ☐

Ethnic & Cultural Orientation:

Interpreter Required? Yes ☐ No ☐

Date of Birth (month - day - year): **PHN:**

Status Card: **SIN:**

Biological Orientation: Male ☐ Female ☐ Other ☐

Gender Identity: Male ☐ Female ☐ Other ☐

Primary Phone Number & Type: **Secondary Phone Number & Type:**

Can I/we leave you a message? Yes ☐ No ☐

Email Address:

* Please Note*: Email correspondence is not protected as a confidential medium of communication.*

What method of correspondence do you prefer using? Phone ☐ Email ☐

Sexual Orientation: Heterosexual ☐ Homosexual/Two-Spirited ☐ Other ☐

Marital Status:

Single ☐ Separated ☐ Common-Law ☐ Married ☐

Divorced ☐ Widowed ☐ Other ☐

Spouse's Name: **Number:**

Dependent Children:

Emergency Contact: **Role:** **Phone Number:**

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Referral Source: | **Phone Number:**

B. MAILING ADDRESS

Street Address:

City: | **Province:**

Postal Code: | **Country:**

House ☐ Condo ☐ Apartment ☐ Basement Suite ☐ Shared ☐ Other ☐

C. HEALTH STATUS

Who is your current family Physician?

Name & Address: | **Phone Number:**

Can I contact them at some point to collaborate services for your care? Yes ☐ No ☐

List any Specialist(s) you've seen in the last five (5) years:

Name & Address:	Phone Number:

Have you previously received any mental health services? (Counselling, Psychiatry, etc.)

Name & Type of Service:	Name & Type of Service:

Are you currently taking any prescription medication (Name, Dose & Frequency)?

Please indicate if you have a registered disability and require accommodations?

Developmental ☐ Intellectual ☐ Learning ☐ Physical ☐ Vision ☐ Hearing ☐

Speech ☐ Mental Health ☐ Other ☐

D. HOLISTIC REFLECTIONS

How do you rate your current *physical health*?

Very Poor ☐ Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent ☐

Please list any current physical health problems you are currently experiencing:

How do you rate your current *sleeping habits*?

Very Poor ☐ Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent ☐

Please list any specific sleeping problems you are currently experiencing:

How do you rate your current *eating choices/habits*?

Very Poor ☐ Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent ☐

Please list difficulties with your appetite and/or eating patterns you are experiencing:

How often do you *exercise*?

Never ☐ Yearly ☐ Monthly ☐ Weekly ☐ 2-3 x Weekly ☐ 3-5 x Weekly ☐ Daily ☐

Please list any problems and/or reasons that prevent you from exercising:

Are you currently experiencing sadness, grief, or depression? Yes ☐ No ☐

If yes, please indicate how often and for how long: _____

Are you currently experiencing any chronic pain? Yes ☐ No ☐
If yes, please describe: _____

_____

Are you currently experiencing anxiety, panic attacks, fear or phobias? Yes ☐ No ☐
If yes, please indicate how often and for how long: _____

_____

Do you drink alcohol?
Never ☐ Yearly ☐ Monthly ☐ Weekly ☐ 2-3 x Weekly ☐ 3-5 x Weekly ☐ Daily ☐

Do you use recreational drugs?
Never ☐ Yearly ☐ Monthly ☐ Weekly ☐ 2-3 x Weekly ☐ 3-5 x Weekly ☐ Daily ☐

Please indicate and list family members (role) if there is a history of any of the following:

Developmental Disorder(s) Yes ☐ No ☐ _____

Alcohol / Substance Abuse Yes ☐ No ☐ _____

Anxiety Yes ☐ No ☐ _____

Depression Yes ☐ No ☐ _____

Obesity Yes ☐ No ☐ _____

Physical / Sexual Abuse Yes ☐ No ☐ _____

Eating Disorder Yes ☐ No ☐ _____

Domestic Violence Yes ☐ No ☐ _____

Obsessive Compulsive Disorder Yes ☐ No ☐ _____

Bi-polar Disorder Yes ☐ No ☐ _____

Schizophrenia Yes ☐ No ☐ _____

Personality Disorder Yes ☐ No ☐ _____

Suicidal Ideation / Attempt(s) Yes ☐ No ☐ _____

E. ADDITIONAL INFORMATION

Are you: Student ☐ Employed ☐ Self- Employed ☐ Unemployed ☐ Other ☐ _____

What is your academic program of study and/or job/career?

_____

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How satisfied are you with your academic program and/or job/career?

Very Poorly ☐ Poor ☐ Satisfied ☐ Good ☐ Very Good ☐ Excellent ☐

What is stressful about your academic program, job/career or life? _____

_____

_____

Do you consider yourself to be spiritual or religious, please describe? _____

_____

_____

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weaknesses? _____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

What are your goals from therapy? _____

_____

_____

_____

What restrictions may affect you participating fully in treatment?

Transportation Issues ☐ Disability Issues ☐ Mobility Issues ☐ Medication Affects ☐

Health-Related Complications ☐ Family Obligations ☐ Other ☐ _____

_____