Mental Health Intake Form

Rapids Family Health Team

Please submit this completed form to:	**RFHT provides structured short term clinical services to those experiencing challenges in their life. Our focus is to provide treatment that is educational & motivates the individual towards developing goals & skills that will support their mental & emotional well-being. Services are offered to individuals 13+**
1150 Pontiac Dr., Sarnia or 233 Cameron St. Corunna Mental health intake worker: 519-339-8949 or Fax: 519-491-2371	

Personal Information

Full Name: _____ Date: _____

Preferred name:_____Gender_____

Full Address:_____

Birthdate (mm/dd/yy)_____Age: _____

Contact #:_____Can a detailed voicemail be left? Yes / No

Is English your first language? Yes/ No. If no, what is your first language? _____

Emergency contact _____ Phone #:_____

Family Physician:_____Referral source:_____

Preparing for the appointment

Are you committed to attending individual therapy to work on your self-identified goals? Yes/No/Unsure

Counsellor preference? _____

Have you received counselling before? Yes / No. When and where?_____

What are some of your strengths?_____

What brings you joy? _____

Please provide details of any recent significant life changes or stressful events?

Todays Presenting and Current Symptoms (Check All That Apply)

☐ Low mood	☐ Racing thoughts	☐ Trouble regulating emotions	☐ Delusions/hallucinations
☐ Feeling hopeless	☐ Excessive worry	☐ Impulsive/risky behaviour	☐ Intrusive thoughts/ memories
☐ Fatigue/ loss of energy	☐ Muscle aches / tension	☐ Irritability/ easily angered	☐ Feeling detached/ numb
☐ Suicidal ideation	☐ Panic attacks	☐ Dramatic mood swings	☐ Guilt/ self blame/ regret
☐ Inability to feel joy	☐ Poor concentration	☐ Memory impairment	☐ Heightened startle reaction
☐ Loss of interest/ motivation	☐ Decreased appetite/ digestive problems	☐ Excessive energy/decreased need to sleep	☐ Avoiding people, places, things

Counselling Objective

What brings you to therapy at this time?_____

_____

What are your goals for therapy? _____

_____

How long have you been dealing with this?_____

Please share some of your current coping strategies?_____

_____

Turn over

Mental Health

Have you been diagnosed with a mental health disorder? Yes/No/Unsure. Please list:_____

Have you ever been hospitalized for mental health? Yes/No. If so, when? _____

Current mental health medications/supplements:_____

Any history of mental illness in your family? Yes/No. Details:_____

History of substance misuse in your family? Yes/No. Details:_____

Has anyone close to you died by suicide? Yes/No. When?_____ Relationship?_____

Are you experiencing suicidal thoughts? Yes/No. If so, how often: Daily□ Weekly□ Monthly□

Have you engaged in self-harm behaviours? Yes/No. How often?_____ Thoughts of harming others? Yes/No

Has your mental health impacted your ability to participate in activities of daily living? Yes/No. How so?_____

_____

History

Who were you primarily raised by?_____ Were you adopted? Yes/No.

Did/do you have a healthy relationship with your mother? Yes/No. How about with your father? Yes/No

Did your parents separate or divorce? Yes/No. How old were you at the time? _____ Did either re-marry Yes/No.

Have you experienced a trauma that effects your life today? Yes/No. Symptoms:_____

How would you describe your childhood?_____

Physical Health

How many times a week do you exercise? _____ Form of exercise:_____

Average hrs of sleep per night _____ Any problems with sleep?_____

Do you eat a well balanced diet? Yes/No/sometimes

Personal concerns with your: alcohol use□ substance use□ gambling behaviour□ other□_____

Are others concerned about your: alcohol use□ substance use□ gambling behaviour□ other□ _____

Please list any specific physical health problems you are currently experiencing. Eg. chronic pain. How do you cope with it:

_____

Present Situation

Status (please circle): Single relationship engaged married common-law separated divorced widowed remarried

Do you have children? Yes/ No. Please List with age_____

Do you have custody of your children? Yes/No. Do you have a healthy relationship with your children? Yes/No

Who do you currently live with?_____

Main source of income: _____ Is your job a source of stress? Yes/No

Have, or are you connected with any other community agencies, resources, supports? Yes/No. Please list:_____

_____

In your life, who do you turn to for support?_____

Do you identify with an cultural group?_____ Is there anything else that you feel is important for a counsellor to know and/or would be helpful?_____

Please fax or submit this completed form to Rapids Family Health Team.