ATTENTION PATIENTS:
DO NOT submit the following forms to your physician's office.
Please call to initiate a referral:
519-339-8949 ext. 107

COMPLETED FORM MUST BE FAXED WITH PHYSICIAN REFERRAL

Rapids
Family Health Team

Mental Health Program: Intake Package

Personal Information

Name:______________________________ Date:______________

Address:______________________________

Preferred contact number(s):______________ Can a detailed voicemail message be left?_____

Date of Birth (dd/mm/yy)______________ Age:________ Gender:______________

Is English your first language? ________ If not, what is your first language?______________

Family Physician:______________________________

Referring Practitioner (i.e. Dietitian, Nurse Practitioner, etc.)______________

Therapy

Are you committed to attending individual therapy? ______________

Do you have a preference for a specific counselor or prefer a male or female counselor?______________

Have you received counseling with the Family Health Team in the past? If so with whom?______________

Have you received therapy/counseling outside of the Family Health Team?______________

Please provide previous therapist/counselor/agency and approximate dates.______________

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Changes in appetite	☐ Second-guessing	☐ Crying spells
☐ Depression	☐ Excessive energy	☐ Fatigue or loss of energy	☐ Guilt
☐ Grief	☐ Low mood	☐ Irritability	☐ Risky activity
☐ Loss of interest	☐ Panic attacks	☐ Racing thoughts	☐ Easily angered
☐ Changes in sleep	☐ Insomnia	☐ Lack of motivation	☐ Memory impairment
☐ Suicidal ideation	☐ Excessive worry	☐ Low self-esteem	☐ Trouble controlling emotions

Physical Health

On average, how often do you exercise:______________________________

Forms of exercise:______________________________

On average, how many hours of sleep are you getting a night?______________

Do you have difficulty falling or staying asleep?______________

Do you have any difficulty eating or have you noticed changes in your appetite?______________

Are you concerned with your alcohol or substance use?______________

Is anyone close to you concerned with your alcohol or substance use?______________

Turn over

Mental Health

Have you ever had a diagnosis or received treatment for a mental illness?_______ Diagnosis?______________________

Have you ever been hospitalized for a mental illness? ______ If so, when?_______________________________________

Is there a family history of mental illness or substance abuse?____

Has a family member been hospitalized for mental illness?____

Has anyone close to you died by suicide? If so what was their relation to you?___________________________________

Have you experienced thoughts of suicide, self-harm, or harm to others? ______If so, how recent/often?_____________

Family History

Were you adopted?_______ If so, at what age? ______ Have you been in contact with your biological parents? _______

Do you have a relationship with your mother? ________________ Is it healthy?_________________________________

Do you have a relationship with your father ? ________________ Is it healthy?_________________________________

Did your parents separate or divorce?____________ If so how old were you at the time?_________________________

Did either parent remarry ? ____________________ If so how old were you at the time?_________________________

Who were you primarily raised by?____

Early Development

How would you describe your childhood?____

Did you experience neglect, trauma or abuse growing up?____

How old were you when you moved out on your own?____

Any major illnesses in your childhood?____

Present Situation

Are you in am intimate partner relationship? ______ If yes, for how long? ____ Is this relationship healthy?_________

Are you legally married?______________________ If yes, for how long?_____________________________________

Are you separated or divorced? _________________ If yes, for how long?_____________________________________

Any prior marriages?_________________________ If yes, how many?____

Do you have children? _____If yes, how many and how old are they? ____

Do you have custody/access of your children?____

Do you have a healthy relationship with each of your children?____

Who do you currently live with?____

What is your source of income? ______If you are employed, is your job a source of stress?_______________________

Are you having difficulty coping with the loss of a friend or family member?__________________________________

Are you a member of a religious or spiritual group?____

Counseling objectives

Please specify what you would like to address, tackle, or focus on in therapy:

____

____

____

____

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