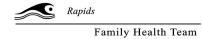
## ATTENTION PATIENTS:

DO NOT thmit the following forms to your physicion's office. Please call to initiate a . ferral: 519-339-8949 ext. 107

## **COMPLETED FORM MUST BE FAXED WITH PHYSICIAN REFERRAL**



## 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?			
Current Symptoms (Check All That Apply)			
	Changes in appetite	Second-guessing	Crying spells
	Excessive energy	Fatigue or loss of energy	Guilt
	Low mood	☐ Irritability	Risky activity
	Panic attacks	Racing thoughts	Easily angered
	Insomnia Excessive worry	Lack of motivation  Low self-esteem	☐ Memory impairment ☐ Trouble controlling
Suicidal ideation	Excessive worry	Low sen-esteem	emotions
Physical Health			
On average, how often do you ex	xercise:		
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 naticed changes in your appetite?			
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			
Ara you in am intimate partner relationship? If you for how long? Is this relationship healthy?			
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:			