

ATTENTION PATIENTS:

DO NOT submit the following forms to
your physician's office.

Please call to initiate a referral:
519-339-8949 ext. 107



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)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Second-guessing | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Fatigue or loss of energy | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Low mood | <input type="checkbox"/> Irritability | <input type="checkbox"/> Risky activity |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Easily angered |
| <input type="checkbox"/> Changes in sleep | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Memory impairment |
| <input type="checkbox"/> Suicidal ideation | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> 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? _____

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 an 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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