ATTENTION PATIENTS:

In order to process your referral this Form MUST be faxed by your Primary Care Provider with the RAPIDS FAMILY HEALTH TEAM REFERRAL FORM.

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
- ☐ Depression
- ☐ Grief
- ☐ Loss of interest
- ☐ Changes in sleep
- ☐ Suicidal ideation
- ☐ Changes in appetite
- ☐ Excessive energy
- ☐ Low mood
- ☐ Panic attacks
- ☐ Insomnia
- ☐ Excessive worry
- ☐ Second-guessing
- ☐ Fatigue or loss of energy
- ☐ Irritability
- ☐ Racing thoughts
- ☐ Lack of motivation
- ☐ Low self-esteem
- ☐ Crying spells
- ☐ Guilt
- ☐ Risky activity
- ☐ Easily angered
- ☐ Memory impairment
- ☐ 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 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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FAX ALONG WITH THE RAPIDS FAMILY HEALTH TEAM PHYSICIAN REFERRAL FORM TO:
519-491-2371