Jan Jelinek, MSc, RPsych #3157

INTAKE FORM

All questions are strictly confidential and will become part of your mental health record.

Name:

Sex: M / F

Today's Date: (DD/MM/YYYY)

Birth Date: (DD/MM/YYYY) **Age:**

Address: **Postal Code:**

Home Phone: **Cell:** **Business:**

Messages can be left at the following phones: Home [ ] Cell [ ] Business [ ]

E-mail:

Marital Status: Single [ ] Partnered [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ]

Partner's Name: **Partner's Occupation:** **Years in relationship:**

Emergency Contact: **Relationship:** **Phone:**

Education (highest level attained)**:**
Grade 11 or Below [ ] High School [ ] GED [ ] Technical [ ]
Undergraduate Degree [ ] Graduate Degree [ ] Major/Area of Concentration: _____

Occupation:
Employed Full time [ ] Employed Part time [ ] Homemaker [ ] Unemployed [ ] Disabled [ ] Retired [ ]

Family physician: **Address:** **Phone:**

Current Medical/Physical Health: [ ] Good [ ] Fair [ ] Poor

(Please list current/past medical problems)**:** _____

_____

Current Medications:_____

_____

Health Habits:

Caffeine: # of cups/day ____ **of:** Coffee [ ] Tea [ ] Cola [ ] Energy Drinks [ ]

Alcohol: # drinks/day ____ **or** # drinks/ week ____ **of**: Beer [ ] Wine [ ] Spirits [ ]

Tobacco: Do you use tobacco? Yes / No # of years using _____ # of years since you quit _____
Cigarettes : # /day [ ] Chew : # /day [ ] Pipe: #/day [ ] Cigars : #/day [ ]

Drugs: Marijuana use: [ ] Daily [ ] Weekly [ ] Monthly [ ] Occasional # of years using _____
Cocaine use: [ ] Daily [ ] Weekly [ ] Monthly [ ] Occasional # of years using _____
Other drug(s): [ ] Daily [ ] Weekly [ ] Monthly [ ] Occasional # of years using _____

Exercise: # minutes/day [ ] # hours/week [ ] **or:** [ ] Occasionally
Describe Routine:_____ _____

Volunteer/Fun Activities: [ ] Daily: # minutes_____ [ ] Weekly: # hours_____ [ ] Monthly: # hours_____
Describe Activity:_____ _____

 # Hours of Sleep/ Night:____ [ ] Trouble falling asleep [ ] Waking at night [ ] Early Morning Wakening

Appetite/ Weight: In the last **2 weeks** have you had an: [ ] Increase [ ] Decrease [ ] No change in appetite
[ ] Loss [ ] Gain [ ] No Change (of more than 5lbs in your weight)

Please indicate whether you or a family member has experienced or been diagnosed with any of the following:

	You	Partner/Spouse	Son/ Daughter	Mother/Father	Brother/Sister	Other Relative
AIDS	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Alcoholism	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Anorexia/Bulimia Nervosa	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Anxiety/ Panic Attacks	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma/ Lung Disorder	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Attention Deficit/Hyperactivity	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Chronic Pain/ Fatigue	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Dementia/ Stroke	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Depression/ Bipolar Disorder	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Domestic Violence	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Drug Abuse	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Epilepsy/ Seizures	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Head Injury	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
High BP/Heart Disease	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Learning Disability	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Nervous breakdown/ Stress	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Neurological Disorder	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Obsessive Compulsiveness	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Personality Disorder	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Schizophrenia/ Psychosis	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Suicide/ Attempted suicide	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Emotional abuse	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Sexual abuse	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Physical abuse	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Other _____	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Please briefly state why you are seeking therapy today: _____

_____

_____

_____

How long has this concern existed? _____ Have you previously attended therapy for this concern? Yes / No

If Yes, where and when did you receive therapy? _____

_____

Type of therapy attended and # of sessions: Individual: [ ] Group: [ ] Couple/ Family: [ ]

Was the treatment helpful? Yes / No / Somewhat