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Psych Intake Form

Intake form Confidentiality Disclosure - Important Please Read

Maintaining confidentiality of your health information is of utmost importance to us. We ask that you please read below for information on the confidentiality of this intake form: One to One Wellness Centre employees and contractors (staff members) adhere to the confidentiality regulations directed by the Personal Health and Information Act (PHIA).

I am aware that this intake form is viewable by other staff members however, will not be accessed unless consent is provided by you to the staff member or to your healthcare provider for the purpose of collaboration with other staff members at One to One Wellness Centre.

If you wish to ensure strict confidentiality between you and your healthcare provider, please stop filling out this form and contact your provider for alternative solutions. If you do not have the contact information of your provider, please call us at 902-425-3775 or email at admin@121wellness.ca and we will happily forward you their information.

Name:_____ Last Name: _____

Email:_____

Preferred Name (if different):_____ Pronouns:_____ Prefix / Title:_____

Intake and Consent Form for Psychological Services / Psychotherapy

Please fill out the following intake form before your session. This will save time in your session. Please know that you may leave any questions blank that you are uncertain about or prefer to not answer at this time. We may review portions of this form in session together. If you have any questions please feel free to let me know in advance. Thank you.

Name of Person Completing the Form:_____ Date:_____

Email:_____

Gender:_____ Relationship Status (if applicable):_____

Number of Children:_____

Information about your children or other family members that you feel is important.

Briefly describe your living situation (what type of home you live in and who you live with).

Medical History

When is the last time you saw your family physician or other doctor for a regular medical check-up or to report concerning symptoms?

How is your physical health at present?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Are you currently receiving psychiatric services, professional counselling, or psychotherapy elsewhere?

☐ Yes ☐ No

Have you ever received psychological services/ psychotherapy or counselling in the past?

☐ Yes ☐ No

If YES to above question, please describe when the services were, what you focused on during the process, as well as your general perception of the experiences and outcomes.

Have you ever been given any formal diagnoses related to cognitive functioning and/or social, emotional issues or mental health? If Yes, please select below:

- ☐ No
- ☐ Learning Disability
- ☐ Major Depressive Disorder
- ☐ Conduct disorder
- ☐ Borderline Personality Disorder
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ ADHD
- ☐ Generalized Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Anger management
- ☐ Eating disorder
- ☐ Autism Spectrum Disorder
- ☐ Social Anxiety Disorder
- ☐ A mood disorder
- ☐ Fibromyalgia
- ☐ Phobia
- ☐ Other

If you selected OTHER above please specify.

If one or more are selected above, please specify when this was diagnosed and by whom.

Are you currently taking taking prescribed psychiatric medication (antidepressants or others)?

☐ Yes ☐ No

If YES, please list:

Health and Social Information

Are you having any problems with your sleep habits?

☐ Yes ☐ No

If YES, please specify (choose all that apply)

- ☐ Sleeping too little
- ☐ Sleeping too much
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Poor quality sleep
- ☐ Disturbing dreams
- ☐ Other

If OTHER, please specify:

How many times per week do you exercise?

Approximately how long each time?

What types of exercise do you do?

Are you having any difficulty with appetite or eating habits?

☐ Yes ☐ No

If YES, select all that apply

☐ Eating less
☐ Binging
☐ Issues with certain foods
☐ Eating more
☐ Restricting
☐ Other

If OTHER, please specify. Or in general please provide more information if you feel it is relevant.

Have you experienced significant weight change in the last 2 months?

☐ Yes - weight gain ☐ Yes - weight loss ☐ No

How many cups of coffee do you drink a day?

0 ☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ more than 3 ☐

Do you regularly use alcohol?

☐ Yes ☐ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

Approximately how often do you use marijuana?

☐ Never
☐ Once a week
☐ Multiple times a day
☐ A couple times a year
☐ A couple times a week
☐ Once a month
☐ Once a day

How often do you engage in other recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you smoke cigarettes, use a vape or other forms of nicotine?

☐ Yes ☐ No ☐ Not anymore

Please share any information that you feel is relevant to your nicotine intake (for example how much and or attempts of stopping).

Have you had thoughts about suicide in the last 3 months?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had thoughts about suicide in the past in general?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Are you currently in a romantic relationship?

☐ Yes ☐ No

If Yes, how long have you been in this relationship?

If in a relationship, on a scale of 1-10 (10 being the highest quality), how would you rate the quality of your current relationship?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

How would you describe your social relationships such as with peers, coworkers or friends?

On a scale from 0 - 10 (10 is extremely satisfied) how satisfied are you with your social life and social relationships in general?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

In the last year, have you experienced any significant life changes or stressors?

In your life have you ever experienced (check all that apply):

- ☐ Extreme Depressed Mood
- ☐ Extreme restlessness for more than 2 days
- ☐ Repetitive Thoughts (e.g. Obsessions)
- ☐ Drastic Mood Swings
- ☐ Drastic, noticeable shift in your personality for more than 2 days
- ☐ Repetitive Behaviors (e.g. Frequent Checking, Hand-Washing)
- ☐ Extreme Anxiety
- ☐ Hallucinations
- ☐ Homicidal Thoughts
- ☐ Panic Attacks
- ☐ Unexplained Losses of Time
- ☐ Suicide Attempt
- ☐ Phobias
- ☐ Unexplained Memory Lapses
- ☐ Sense of disconnection from your body or physical space
- ☐ Gender dysphoria (unease because of sense of mismatch between your experienced gender and body or assigned sex)
- ☐ Alcohol/Substance Abuse
- ☐ Gambling issues
- ☐ Frequent Body Complaints
- ☐ Legal issues Sleep Disturbances
- ☐ Eating Disorder
- ☐ Physical violence
- ☐ Extreme agitation for more than 2 days
- ☐ Body Image Problems
- ☐ Forms of abuse

If you selected any above briefly describe when this was and any detail you think may be important for me to know.

Occupational and Education Information

Are you currently employed and/or working? ☐ Yes ☐ No

If YES, briefly describe your current position, who is your employer, what you do for work and if you work online or in person.

If YES, please rate between 1-10 (10 being highest) your level of satisfaction with your current employment/ work.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Please list any work-related stressors, if any?

Are you currently in school and/ or courses? ☐ Yes ☐ No

If YES, please briefly describe the school (the name of program/course, the name of school, online or in person, full time or part time).

If you are in school/courses, please rate your current level of satisfaction between 1-10 (10 being high) with the experience.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Spiritual/Religious Information

Do you consider yourself to be religious? ☐ Yes ☐ No

If YES, what is your faith?

Do you consider yourself to be spiritual? Please share any information that you would like me to know.

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety Disorders
- ☐ Panic Attacks
- ☐ Schizophrenia
- ☐ Alcohol/Substance Abuse
- ☐ Eating Disorders
- ☐ Learning Disabilities
- ☐ Trauma History
- ☐ Suicide Attempts
- ☐ Crime
- ☐ Gambling
- ☐ Domestic violence or abuse

If you selected above please specify their name, relationship to you and any concise details you feel are important for me to know. Remember we always have time to discuss in session.

Other Information

What do you consider to be your strengths?

What do you like about yourself?

What are effective coping strategies that you've learned?

What are your potential goals or desired outcomes for therapy?

Any additional information you would like your therapist to know prior to your initial meeting?

Communication

Appointment Notifications and Reminders

Email:
You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

I would like email notifications of new, cancelled, and rescheduled appointments

Email 7 days before appointment

Text Message (SMS):
Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

Text Message (SMS) 2 days before appointment

Text Message (SMS) 1 hour before appointment

Accuracy of Information

I certify that the above medical information is correct to my knowledge.

Signature: _____ Date: _____