**ADULT INTAKE QUESTIONNAIRE**

**Information About You:**

Name:

Date of birth:

Phone number:

Address:

Health card Number and Province:

Who should we contact in case of an emergency (please list at least 2 contacts):

Please list the name, address, phone number, and fax number for your primary medical doctor/provider.

Please provide the name of your pharmacy, address, phone number and fax number for your prescriptions to be sent to.

Do you have any strong cultural or religious beliefs: If so, please describe.

**Present Concerns:**

What are your main concerns for you to be seen at this practice:

How long have these issues been going on for:

Please place an X next to each problem you experience **presently**:

Depressed mood:

Loss of interest or enjoyment in activities you previously enjoyed:

Poor sleep:

Feelings of guilt:

Feelings of worthlessness:

Feelings of hopelessness:

Poor energy:

Poor concentration due to low mood:

Poor appetite:

Feeling sluggish or weighed down:

Being easily distracted:

Being very irritable:

Feeling like you are on top of the world or like you have super powers:

Racing thoughts:

Excessive activity:

Little need for sleep for days in a row:

Panic attacks:

Fear of using public transportation:

Fear of being in open spaces:

Fear of being in enclosed spaces:

Fear of being outside of the home alone:

Excessive and intense worrying about potential judgement or criticism in social settings:

Avoiding meeting new people or being involved in social interactions:

Excessive worrying about everyday life events and tasks:

Feeling restless, keyed up, or on edge:

Poor concentration due to being distracted with worries:

Muscle tension when worried:

Repeatedly checking things:

Excessive hand washing or cleaning:

Compulsive need for neatness/order:

Rituals or routines you feel you must perform:

Needing to do things a certain number of times or constantly counting things:

Need for symmetry:

Restricting what you eat to lose weight or avoid gaining weight:

Binge eating episodes:

Forcing yourself to throw up after eating excessively:

Taking laxatives after eating excessively:

Exercising excessively because of poor body image:

Difficulties relating to others in social situations:

Problems making and/or maintaining friendships:

Difficulty in interpreting non-verbal cues in social situations:

Problems with purposeless repetitive movements or repeating words/phrases:

Problems with changes in routines and habits:

Tendency to have intense fixated interests or hobbies:

Sensory issues (sound, light, textures, pain, temperature):

Failing to give close attention to details or making careless mistakes often or very often:

Difficulty sustaining attention often or very often:

Not listening when others are speaking directly to you often or very often:

Struggling to follow through on instructions often or very often:

Difficulty with organization often or very often:

Avoiding or disliking requiring a lot of thinking often or very often:

Losing things often or very often:

Being easily distracted often or very often:

Being forgetful in daily activities often or very often:

Fidgeting with hands or feet or squirming in chair often or very often:

Difficulty remaining seated often or very often:

Running around or climbing excessively in children often or very often; extreme restlessness in adults:

Difficulty engaging in activities quietly often or very often:

Acting as if driven by a motor often or very often; adults will often feel inside like they were driven by a motor:

Talking excessively often or very often:

Blurting out answers before questions have been completed often or very often:

Difficulty waiting or taking turns often or very often:

Interrupts or intrudes upon others often or very often:

Hallucinations:

Feeling like people are watching you or are after you:

Grief/loss:

Chronic pain issues:

Difficulty with work, school, or family:

**Mental Health History:**

Have you been given any mental health diagnoses in the past:

 If yes, please list:

Have you ever been in mental health treatment (not including psychiatric hospitalizations):

If yes, where (list all) and what kind of treatment:

When were you in treatment:

Was the treatment helpful: Why or why not:

Have you ever taken medication to help with behavior, mood, or other mental health problems:

If yes, what medication(s):

What medication was helpful:

Did you have any side effects from the medication:

Have you ever been admitted to the psychiatric hospital:

If yes, where:

When were you admitted to the psychiatric hospital:

Have you ever been seen in a psychiatric emergency room but not admitted to the hospital:

If yes, where and when:

Have you ever had any suicidal thoughts, suicide attempts or self-injurious behaviors (cutting, self-mutilation, etc):

 If yes, please describe:

Have you ever had any thoughts of hurting others:

 If yes, please describe:

Do you have any history of violence or aggression:

If yes, please describe:

**History of Trauma or Abuse:**

Have you ever experienced any trauma or abuse (emotional, physical, or sexual):

If yes, please describe the traumatic event or abuse:

**Family History:**

Please list any **mental illnesses** (depression, anxiety, bipolar disorder, schizophrenia, autism, intellectual disability, ADHD, etc) experienced by the following family members:

Mother:

Father:

Siblings:

Mother’s parents:

Father’s parents:

Any other family members:

Please list any family members that **have alcohol or drug problems** and explain:

Mother:

Father:

Siblings:

Mother’s parents:

Father’s parents:

Any other family members:

Has anyone in your family (mother’s and father’s side) attempted or committed suicide:

If yes, who:

Does anyone in your family (mother’s and father’s side) have a history of legal problems or incarcerations:

If yes, who:

Do any of the following family members suffer from medical problems (asthma, diabetes, high cholesterol, high blood pressure, thyroid problems, cancer, heart disease or heart attack, stroke, etc): If “Yes,” please explain. Also, if the medical condition is a heart problem, please indicate the age that the condition began.

Mother:

Father:

Siblings:

Mother’s parents:

Father’s parents:

Any other family members:

**Living situation and marital status:**

Who do you live with:

What is your marital status:

**Educational, Employment, Military and Legal History:**

Where were you born and raised:

Who was in your family growing up:

Who is/are part of your support system:

What do you currently do for work:

How long have you been in your current work position:

What is the highest level of education that you have completed:

Have you ever had any history with the legal system:

Do you have any military history:

**Hobbies, interests, spirituality:**

Please tell us about any important hobbies, interests or spiritual beliefs or practices you would like us to know about:

**Substance Abuse History:**

Do you smoke cigarettes or vape nicotine:

 If yes, how much do you use each day:

 When did you start smoking or vaping:

Do you regularly drink caffeine:

 If yes, how much do you drink each day:

Does it cause you any problems, like feeling anxious or jittery or having a hard time sleeping:

Do you currently drink alcohol:

 If yes, how often:

 How much do you drink when you do:

 Does your alcohol use cause you any problems:

 Have you had problems with alcohol in the past, if not now:

Do you currently use any drugs (including marijuana):

 If yes, what drugs:

How often:

 How much do you use when you do:

 Does your drug use cause you any problems:

 Have you had problems with drugs in the past, if not now:

Have you ever participated in substance abuse treatment, such as detox, rehab, or outpatient treatment:

 If yes, please describe:

**Developmental history:**

What was your birth weight:

What was your gestational age at birth:

Were you born by C-section or vaginal delivery:

Any complications during the pregnancy with you:

 If yes, please give details:

Any complications during your birth or after your birth:

 If yes, please give details:

Did you require stay in the NICU:

If yes, please give details:

Were you ever exposed to any alcohol, tobacco, illicit drugs or prescription drugs in-utero:

 If yes, please give details:

Did you reach your developmental milestones on time:

**Current Medications:**

Please list all **medications** (for medical and psychiatric reasons, including prescription and over-the-counter medication, and doses and when you take the medication, such as each morning or on Sundays) that you take at this time and **why** you take the medication:

If you take medication, do you find it helpful: For either answer, please explain:

**Medical History:**

Do you have any medical problems:

If yes, please list all medical problems:

Have you ever had one of the following: If “Yes,” please explain.

 Surgery:

 Medical hospitalization:

 Head injury:

 Seizures:

 Heart problems:

Do you have any allergies:

If yes, please list the medication and what the reaction is:

Other than your primary medical doctor that you listed above, do you see any other medical doctors/providers:

If yes, who (please include the name, contact information, and reason you meet with this person):

When was your last physical exam:

When was your last bloodwork:

 Was anything abnormal:

If you know, please list what these were when last checked:

 Blood pressure:

 Heart rate:

 Height:

 Weight:

If you are female:

When was your last menses:

Are you or could you be pregnant:

Any menopausal issues:

**Further Information (Please feel free to add any further information that you feel is important but not previously asked in this questionnaire):**