Client Intake - Psychiatry

First Name: _____ **Last Name:** _____

Gender Identity / Pronouns: _____

Date of Birth *(MM/DD/YYYY)*: _____ **PHN:** _____

Address: _____ **City:** _____

Province: _____ **Postal Code:** _____

Email Address: _____ **Phone:** (_____) _____-_____

Preferred Method of Contact: ☐ Email ☐ Phone

Emergency Contact

Name: _____ **Phone:** (_____) _____-_____

Relationship: _____

Current Psychiatrist:

_____ _____
Name *Clinic*

Primary Care Physician:

_____ _____
Name *Clinic*

Current Psychologist/Psychotherapist:

_____ _____
Name *Clinic*

How did you hear about us?

☐ Website ☐ Facebook ☐ Personal (word of mouth)

☐ Healthcare Provider ☐ Other: _____

Medications

Please provide us with the name and daily dose of all prescription medications you are currently using.

Medication Name	Dose	Reason

Non-prescription Medication Use

Please tell us if you use prescription or non-prescription medications. Indicate which medications, the dosage, and how often you use them:

Vitamin and Supplement Use

Medical History

Allergies

Please provide us with a list of your allergies:

History of Surgical Procedures

Please provide us with the procedure name and date of all previous surgeries.

History of Anesthesia Problems

Please list any problems you or your family members have had with anesthesia.

Are you currently pregnant? ◯ Yes ◯ No

Do you have difficulty getting your point across because you ramble or go off the track a lot when you talk? ◯ Yes ◯ No

Please indicate which, if any, of the following medical conditions you and/or your family member(s) have been diagnosed with currently or in the past.

Neurological (Brain) Conditions

Stroke
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Epilepsy
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Concussion
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Cardiac (Heart) Conditions

High Blood Pressure
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Heart Attack
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Heart Murmur
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Heart Disease
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Gastro-Intestinal & Liver Conditions

Crohn's Disease
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Irritable Bowel Syndrome (IBS)
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Hepatitis
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Endocrinology

Diabetes
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Thyroid Issues
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Renal (Kidney) Conditions

Renal Failure
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Dialysis
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Pulmonary (Lung) Conditions

Asthma
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

COPD
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Tobacco Use
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Orthopedic (Bone) Conditions

Fractures
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Rheumatoid Arthritis
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Osteo-Arthritis
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Other

Fibromyalgia
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

RSD/CRPS (Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome)
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Glaucoma
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Cancer
☐ *Self* ☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Mental Health History

Please indicate which, if any, of the following conditions you and/or your family member(s) have been diagnosed with currently or in the past.

Depression

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

PTSD

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Schizophrenia

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Borderline Personality Disorder (BPD)

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Bipolar Disorder

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Psychosis

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Anxiety

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Suicide Attempts / Ideation

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Drug Abuse

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Alcohol Abuse

☐ *Self (Date diagnosed: _____)*
☐ *Mother* ☐ *Father* ☐ *Sibling(s)* ☐ *Partner*

Please take a few moments to answer a few questions about yourself.

Marital Status

☐ Single ☐ Married/Long term relationship ☐ Divorced
☐ Widowed ☐ Remarried

Children: ◯ No ◯ Yes *(Please list their ages)*:_____

Number of People in Household: _____

Occupation: _____ **Employer:** _____

Level of Education: _____

Hobbies:

Do You Exercise? ◯ Yes ◯ No

If yes, please tell us how often and how intense your workouts are (on a scale of 1-10, with 10 being the maximum intensity):

How many meals do you eat per day? _____

Alcohol Consumption

When was the last time you consumed alcohol? _____

How much and what kind did you consume? _____

What is your average weekly alcohol intake (in servings)? _____

Are You Concerned About Your Alcohol Intake? ◯ Yes ◯ No

Stress Triggers

What are the biggest stressors in your life?

I Am Not Happy With...

- ☐ Myself
- ☐ My relationships (partner, children, extended family etc.)
- ☐ My health
- ☐ My work
- ☐ My life history

Signature

I, the undersigned, certify that I have the legal authority to release the information entered within this document, and that it is accurate and complete to the best of my knowledge.

_____	_____	_____
Print Name	*Signature*	*Date*

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score