INTEGRATE
HEALTH SERVICES

ADULT PSYCHOLOGICAL ASSESSMENT INTAKE

**** In order for us to provide an accurate assessment, please complete the following intake form to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your client file, it is your choice to limit that information.***

Date: _________________ How did you hear about our services? ____________________________________

What kind of assessment are you interested in? ____

CLIENT INFORMATION:

Name: _______________________________ D.O.B _____________ Age ______ Gender: ☐ M ☐ F ☐ Other

Address: ____ City: ________________ Postal Code: ___________

Does your child have a diagnosis or exceptionality?____

Marital Status:

☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed -Please indicate date: __________ or ☐ Single

Have you been married before? *If yes, indicate date(s):* _________________________

Do you have a diagnosis or exceptionality?____

Email * (We will use email for important correspondence):____

***Please add me to your mail list so that I receive information about programs and services*: ☐ Yes ☐ No**

Home Phone: (________)______________________Cell Phone: (________)____________________________

Occupation: ______________________________________ ☐ Student

Employer (School, if student): _____________________ Work/School Phone: (________)_________________

SPOUSE/ PARTNER'S INFORMATION (If Applicable)

Spouse/Partner's Name: ______________________ D.O.B: _______ Age _____ Gender: ☐ M ☐ F ☐ Other

Address: ☐ Same as above OR _____________________________ City: ____________ Postal Code:________

Phone:(______)________________________ Occupation: ____

Employer: ___________________________________ Work Phone: (___________)______________________

EMERGENCY CONTACT:

Name: ____ Relationship: ____________________________

Main contact # (   ) ____________________________ Alternate # (   ) _____________________________

REFERRAL SOURCE (if applicable)**:**

Name: ____ Specialty: _______________________________________

Address ____ Phone #_______________ Fax # _________________

Do we have your permission to release information to the referring professional ☐ Yes ☐ No

REASONS FOR ASSESSMENT

What is the main reason for this assessment? *(**Please give a brief summary of the main problems):***

What do you hope to achieve, improve or change? *(**What are your goals in being here?):***

Previous/current contact with Mental Health Professionals or Support Services:

Name of Agency	Professional Involved	Type of Treatment (medication, counselling, etc.).	Date and Duration of Treatment	Was it effective?

Are you on a waitlist of any services?

MEDICAL HISTORY (childhood-adulthood):

Present Height: _________________ Present Weight: ______________

Current life stresses ***(include anything that is currently stressful for you, examples include relationships, job, school, finances, children):***

Current supplements/vitamins/herbs:____

Prenatal and birth events: Your parent's attitude toward their pregnancy with you ______________________

Pregnancy length: __________________________ (on-time, late, early)

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.: ____

Any birth problems, trauma, forceps or complications?: ____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

1. **Major Illnesses** No [ ] Yes [ ]

Year	Illness	Treatment	Result

2. **Surgery** No [ ] Yes [ ]

Year	Type of Surgery	Reason for Surgery	Result

3. **Hospitalizations** No [ ] Yes [ ]

Year	Illness	Treatment	Result

4. **Injuries/Accidents** No [ ] Yes [ ]

Year	Injury

5. **Physical/Sexual Abuse** No [ ] Yes [ ]

Year	Include unreported injuries/untreated injuries	By spouse/partner/family member/other

6. Allergies No ☐ Yes ☐

Drugs/Food/Environment	Type of Reaction: Allergy or Side Effect	Clarification / Allergy or Side Effect

Have you ever had the following?

Seizures: ☐ Yes ☐ No ☐ Unknown Type: ____

Age when seizures started: ___________________ Name(s) of medication(s) given: __________________________________

Head injury leading to unconsciousness or evaluation by a physician? ☐ Yes ☐ No ☐ Unknown

If yes, please describe:

Has a CT scan or MRI scan of the brain be completed? ☐ Yes ☐ No ☐ Unknown

If yes, was it described to be normal? ☐ Yes ☐ No ☐ Unknown

Prior abnormal lab tests, X-rays, EEG, etc.? ☐ Yes ☐ No ☐ Unknown

If yes, please describe:

Primary Physician:		
Name:	Address:	Phone Number:
Other Health Care Providers/ Clinics Seen Regularly:		
Name: Specialty:	Address:	Phone Number:
Name: Specialty:	Address:	Phone Number:
Name: Specialty:	Address:	Phone Number:

EDUCATION AND EMPLOYMENT:

School History: Last grade completed ____________ Last school attended ____________________________

Average grades received ______________ Specific learning disabilities ________________________________

Learning strengths ____

Any behavior problems in school? ____

What have teachers said about you ____

**Please bring school report cards and and/or special testing or assessments that have been performed.*

Employment History:

Date	Duration of Employment	Position	Reason for Leaving

Any work-related problems? ____

What would your employers or supervisors say about you? ____

Military History? (if yes, please include dates and describe experience):

CLIENT HISTORY:

History or current legal problems?

Sexual History:

Are you sexually active? ☐ Yes ☐ No Sexual Concerns:

Alcohol and Drug History: Please list substances you have used from childhood to adulthood.

Type of Substance	Period of Use	How much of the substance would you consume?	Did you stop? Why/why not?

Ever experience withdrawal symptoms from alcohol or drugs? ____

Has anyone told you they thought you had a problem with drugs or alcohol? ___________________________

Have you ever felt guilty about your drug or alcohol use? ____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? ________________

Have you ever used drugs or alcohol first thing in the morning?_______________________________________

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____________________________________

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) ___________________

How has drug and alcohol use affected school/work situations? _______________________________________

Have you tried to stop drug or alcohol use and have been unsuccessful? (if so, please indicate how many times and at what ages____

FAMILY HISTORY:

Please complete:

Family Contacts	**Biological**	**Step/Half**	**Adoptive**	**Foster/Guardian**
Parent/Guardian ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Parent/Guardian ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Sibling 1 ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 2 ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 3 ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 4 ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 5 ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 6 ☐ M ☐ F ☐ Other	Name (age)	Name (age)	Name (age)	Name (age)

BIRTH MOTHER'S HISTORY:

Birth mother's age: _____________ Profession: ____

Education (highest grade completed): ____

Learning /Behaviour problems: ____

Childhood atmosphere (family position, abuse, illnesses, etc.):

BIRTH FATHER'S HISTORY:

Birth father's age: _____________ Profession: ____

Education (highest grade completed): ____

Learning /Behaviour problems: ____

Childhood atmosphere:

M=Mother; F=Father; S=Sister, B=Brother, N= Niece/Nephew				**Use Sib #**						**Use Child #**	**Mother's**		**Father's**	
Family Psychiatric History	No History	M	F	S	B	N	Aunts	Uncles	Cousins	Children	MM	MF	FM	FF
ADHD/ADD														
Aggression/Violence/Abuse														
Alcohol Abuse														
Anxiety														
Autism Spectrum Disorders														
Bipolar Disorder														
Dementia (Early/Late)														
Depression														
Drug abuse														
Eating Disorders														
Imprisonment/Detention														
Learning Disabilities														
Mental Retardation														
Obsessive Compulsive Disorder														
Oppositional Defiant Disorder														
Schizophrenia														
Suicide (Failed Attempts)														
Suicide (Successful Attempts)														
Tourette’s Disorder														
Any psychiatric hospitalization														
Other:														
Family Medical History	No History	M	F	S	B	N	Aunts	Uncles	Cousins	Children	MM	MF	FM	FF
Asthma														
Cancer:														
Diabetes Mellitus														
Heart Disease														
High Blood Pressure														
Irritable Bowel or Colitis														
Migraine Headaches														
Mitral Valve Prolapse														
Seizures (Epilepsy)														
Stroke														
Thyroid Disorder														
Ulcers														
Other:														
Age at Death														
Year of Death														
Cause of Death														
Unexpected Death														

CLIENT FAMILY RELATIONSHIPS:

Who lives in your current household? (please give relationship to each person)

Name	Age	Relationship

Current Marital or Relationship Satisfaction:

Significant Developmental Events: (marriages, divorces, deaths, traumatic events, losses, abuse, etc.)

History of Past Marriages:

Cultural/Ethnic Background:

Describe your relationships with friends:

Describe yourself/your strengths:

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General

- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other_____________________

Neurological

- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other_____________________

Respiratory

- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other_____________________

Head, Eye, Ear, Nose, & Throat

- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_________________________

Gastrointestinal and Hepatic

- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_____________________

Musculoskeletal

- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_________________________

Genitourinary

- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other________________________

Females

- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other_________________________

Males

- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other_______________________

Explanation

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INFORMED CONSENT

Thank you for your interest in Integrate Health Services. Please be aware that all client information will be stored as confidential clinic records. Where assessment services are provided, information shared will become part of a consult letter, which will be forwarded to the client and referring physician. Any additional information shared outside the clinic would require the written permission of the client.

CONFIDENTIALITY:

There are by law, certain circumstances in which confidentiality cannot be maintained.
These situations would include: (1) suspected child abuse or neglect (2) circumstances where the client has become a danger to themselves or others, (3) when information has been subpoenaed by the court. Should you have any questions about the limits of confidentiality, please contact an Integrate Health Services team member.

APPOINTMENTS:

Please ensure you arrive on time for your scheduled appointment, as we are unable to extend your session time. No show appointments will be subject to a half-session charge.

INTEGRATE HEALTH SERVICES TEAM APPROACH- CIRCLE OF CARE:

Integrate Health Services is a multi-disciplinary team working in partnership with The Kids Clinic. We are comprised of various health professionals and in circumstances where it is believed to be in the best interest of the client, please be aware that personal health information may be shared among healthcare providers at Integrate Health Services and Kids Clinic. Information shared will be determined on a case-by-case basis dependant upon the needs of the individual client(s). *When you access Speech Therapy or Occupational Therapy Services, please be aware that the information you provide to Integrate Health Services is shared with our partners, Speech Therapy Centres of Canada and Ashley Rego Occupational Therapy Services. By signing this form, you are consenting to all services provided through Integrate Health Services, including those affiliated with Speech Therapy Centres of Canada and Ashley Rego Occupational Therapy Services and understand that the same limits of confidentiality apply.

Integrate Health Services provides the following additional programs and services:

- *Psychological Assessments*
- *Counselling Services*
- *Art Therapy*
- *Behavioural Therapy- Applied Behaviour Analysis (Comprehensive and Focused ABA)*
- *Behaviour Consultation*
- *Child/Youth/Adolescent Group Programs*
- *Parent Support and Skills Training*
- *Education Services*
- *Speech and Language Therapy (through our partnership with speech therapy centres of Canada)*
- *Occupational Therapy Services (through our partnership with Ashley Rego Occupational Therapy Services)*

CLIENT CONSENT:

I, ____ have reviewed the above information and fully understand the details of informed consent. An Integrate Health Services team member has answered any questions I had. At this time, I make an informed choice to access services at Integrate Health Services.

____________________________________	_______________________________	______________________
Client Name	Signature	Date
____________________________________	_______________________________	______________________
Witness Name	Witness Signature	Date

APPOINTMENT CANCELLATION POLICY

1. Our policy is 24-hour (1 business day) cancellation for all scheduled appointments. For example, if your appointment is scheduled for Monday at 10 a.m., you must cancel the appointment no later than 10 a.m. the Friday before the appointment. If the appointment is on Wednesday at 2 p.m., it must be cancelled no later than Tuesday at 2 p.m.

* Missed appointments without any prior notice may be subject to a cancellation fee up to a full session charge. **This fee cannot be billed to a third party funder or grant and must be paid directly by the client.**

2. To cancel an appointment, please call 905-683-7228.

If you cannot reach us in person or by phone, you may leave a detailed voice message with your name, date and time of your scheduled appointment and your request to cancel or reschedule.

I, ____ have reviewed and agree to the above stated policy regarding appointment cancellation.

___________________________________ Client Name

___________________________________ Client Signature

___________________________________ Date