**Client Intake Form**

**Tel**: 905-780-1470 **Fax**: 647-699-9812

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| **Name** |  |
| **Date of Birth** |  |
| **Date Completed** |  |

**How To Use:**

* You will be meeting with a psychiatrist (a medical doctor that is trained in mental health) who will want to know as much about you as they can.
* The attached forms are used to learn valuable background information. We realize some of this information may be difficult to remember, but please feel free to collaborate with your therapist, pharmacy, or others who may be able to help you gather this information. Your mental health and medical histories are essential to making decisions about your treatment going forward. Please feel free to be approximate if the exact information is not known.
* The information you provide here is confidential and will only be seen by your treatment program (including therapists and counsellors) and the Psychotherapy Matters Virtual Clinic team (including the psychiatrists and support staff.)
* Think of this document as a valuable summary of your own records and try to keep it up to date in the future.

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| **Medication for Mental Health Issues**  No Medication History | | | | | | | |
| **Disclaimer**: Medications are sorted into categories that represent what they are ***most commonly used for***. | | | | | | | |
| **ANTIDEPRESSANTS** | | | | | | | |
| **Generic Name** | **Trade Name** |  | **Past** |  | **Present** |  | **Notes (ex. was it helpful, side effects?)** |
| Amitriptyline | Elavil |  |  |  |  |  |  |
| Bupropion | Wellbutrin |  |  |  |  |  |  |
| Citalopram | Celexa |  |  |  |  |  |  |
| Clomipramine | Anafranil |  |  |  |  |  |  |
| Duloxetine | Cymbalta |  |  |  |  |  |  |
| Escitalopram | Cipralex |  |  |  |  |  |  |
| Fluoxetine | Prozac |  |  |  |  |  |  |
| Fluvoxamine | Luvox |  |  |  |  |  |  |
| Imipramine | Tofranil |  |  |  |  |  |  |
| Mirtazapine | Remeron |  |  |  |  |  |  |
| Nortriptyline | Aventyl |  |  |  |  |  |  |
| Paroxetine | Paxil |  |  |  |  |  |  |
| Sertraline | Zoloft |  |  |  |  |  |  |
| Venlafaxine | Effexor |  |  |  |  |  |  |
| Trazodone | Desyrel |  |  |  |  |  |  |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
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| **MOOD STABILIZERS** | | | | | | | |
| **Generic Name** | **Trade Name** |  | **Past** |  | **Present** |  | **Notes (ex. was it helpful, side effects?)** |
| Carbamazepine | Tegretol |  |  |  |  |  |  |
| Lithium | Carbolith |  |  |  |  |  |  |
| Lamotrigine | Lamictal |  |  |  |  |  |  |
| Topiramate | Topamax |  |  |  |  |  |  |
| Valproate | Depakote |  |  |  |  |  |  |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
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| **ANTIPSYCHOTICS** | | | | | | | |
| **Generic Name** | **Trade Name** |  | **Past** |  | **Present** |  | **Notes (ex. was it helpful, side effects)** |
| Aripiprazole | Abilify |  |  |  |  |  |  |
| Clozapine | Clozaril |  |  |  |  |  |  |
| Fluphenazine | Modecate |  |  |  |  |  |  |
| Haloperidol | Haldol |  |  |  |  |  |  |
| Olanzapine | Zyprexa |  |  |  |  |  |  |
| Quetiapine | Seroquel |  |  |  |  |  |  |
| Trazodone | Desyrel |  |  |  |  |  |  |
| Ziprasidone | Zeldox |  |  |  |  |  |  |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
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| **ANTI-ANXIETY AND INSOMNIA** | | | | | | | |
| **Generic Name** | **Trade Name** |  | **Past** |  | **Present** |  | **Notes (ex. was it helpful, side effects)** |
| Alprazolam | Xanax |  |  |  |  |  |  |
| Buspirone | Buspar |  |  |  |  |  |  |
| Clonazepam | Rivotril |  |  |  |  |  |  |
| Diazepam | Valium |  |  |  |  |  |  |
| Lorazepam | Ativan |  |  |  |  |  |  |
| Temazepam | Restoril |  |  |  |  |  |  |
| Zolpidem | Sublinox |  |  |  |  |  |  |
| Zopiclone | Imovane |  |  |  |  |  |  |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
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| **STIMULANTS** | | | | | | | |
| **Generic Name** | **Trade Name** |  | **Past** |  | **Present** |  | **Notes (ex. was it helpful, side effects)** |
| Amphetamine | Adderall |  |  |  |  |  |  |
| Amphetamine (slow release) | Concerta |  |  |  |  |  |  |
| Atomoxetine | Strattera |  |  |  |  |  |  |
| Methylphenidate | Ritalin |  |  |  |  |  |  |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |
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| **Substance Use History**  No Substance Use History | | |
| **Substance** |  | **Pattern Of Usage** |
| Acid/LSD |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Alcohol |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Benzodiazepines (xanax, ativan) |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Cannabis (weed, marijuana) |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Cigarettes/Tobacco |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Cocaine |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Codeine |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Crack |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Crystal Meth |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Ecstasy/MDMA |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Fentanyl |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| GHB |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Heroin |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Inhalants (aerosol sprays, gases, nitrites) |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Ketamine (Special K) |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Prescription Drug Abuse (opioid pain killers) |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Daily  Weekly  Occasionally  Binges  Once in my life |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Daily  Weekly  Occasionally  Binges  Once in my life |

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| **Past Psychiatric History** | | | | | | |
| **COUNSELLING/THERAPY**  **Have you ever received counselling/therapy before?  No  Yes**  **If yes, please explain why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **Reason** |  | **Past** |  | **Present** |  | **With (name and/or credential)** |
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| **DIAGNOSES**  **Have you ever been diagnosed with a mental disorder?  No  Yes**  **If yes, what was the diagnosis(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
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| **HOSPITALIZATIONS**  **Have you ever been hospitalized for mental health reasons?  No  Yes**  **If yes, describe why, when, and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Reason** |  | **Date/Age** |  | **Where** |
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| **Allergies**  No Allergies |
| **Please list all allergies:** |
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| **General Health History**  No General Health History | | | | |
| **Personal Medical History** |  | **Check All that Apply** |  | **Notes (ex. treatment, surgery)** |
| Anemia |  |  |  |  |
| Arthritis |  |  |  |  |
| Asthma/respiratory problems |  |  |  |  |
| Cancer (type) |  |  |  |  |
| Chronic Pain |  |  |  |  |
| Diabetes |  |  |  |  |
| Epilepsy or seizures |  |  |  |  |
| Fibromyalgia |  |  |  |  |
| Head Trauma |  |  |  |  |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| High Cholesterol |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Liver Disease |  |  |  |  |
| Liver Problems |  |  |  |  |
| Stomach or intestinal problems |  |  |  |  |
| Surgery/hospitalizations |  |  |  |  |
| Other (please specify): |  | | | |
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| **Medication History for General Health**  **(ex. blood pressure medication)**  No Medication History | | | | | | | | |
| **Medication Name** |  | **Issue** |  | **Past** |  | **Present** |  | **Notes** |
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