Rapids
Family Health Team

# Mental Health Intake Form

RFHT provides structured short term clinical services to those experiencing challenges in their life. Our focus is to provide treatment that is educational & motivates the individual towards developing goals & skills that will support their mental & emotional well-being. Services are offered to patients of the RFHT to individuals 13 + who have exhausted their EAP Benefits and/or Group Insurance.
**ATTENTION:** Complete form and submit to 1150 Pontiac Dr., Sarnia; online application available @rapidsfhteam.ca/referral forms

## Personal Information

Date:_____ First name: _____ Last Name: _____
Preferred Name: _____ Preferred Pronoun: _____
Gender: _____ Address: _____
Health Card Number #_____
Date of Birth: _____ Age: _____
Preferred contact number: _____ Can a detailed voicemail message be left? Yes☐ No☐
Email: _____ Can a detailed email be left? Yes☐ No☐
Emergency contact: _____ Relationship: _____ Phone number:_____
Is English your first language: Yes☐ No☐ If not, what is your first language? _____
Family Physician: _____ Referral Source:☐Self ☐other: _____

## Physical Health

Do you exercise regularly: Yes☐ No☐ infrequent☐ Details: _____
On average, how many hours of sleep are you getting a night? _____
Do you have any problems with sleep? Yes☐ No☐ Explain: _____
Do you have any difficulty eating or have you noticed changes in your appetite? Yes☐ No☐
Explain: _____
Please list any current specific physical health problems you are experiencing: (i.e.: Chronic pain) _____
If so, how do you cope with it?

## Current Symptoms (Check All That Apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Grief
- ☐ Low mood
- ☐ Feeling hopeless
- ☐ Low self-esteem
- ☐ Inability to feel joy
- ☐ Excessive Worry
- ☐ Lack of motivation
- ☐ Guilt/blame/regret
- ☐ Fatigue/loss of energy
- ☐ Decreased appetite
- ☐ Memory impairment
- ☐ Poor Concentration
- ☐ Panic attacks
- ☐ Easily startled
- ☐ Dramatic mood swings
- ☐ Increased irritability
- ☐ Easily angered
- ☐ Delusions/Hallucinations
- ☐ Panic attacks
- ☐ Feeling detached/numb
- ☐ Trouble controlling emotions
- ☐ Intrusive thoughts
- ☐ Intrusive memories
- ☐ Substance misuse
- ☐ Engage in risky behaviours
- ☐ Self-harm (☐daily☐weekly☐monthly☐other)
- ☐ Suicidal ideation (☐daily☐weekly☐monthly☐other)

## Relationships

Relationship Status☐Single☐relationship☐engaged☐married/common-law☐separated/divorced☐widowed☐remarried
If so, how long have you been in your current relationship? _____
Is this relationship healthy? Yes☐ No☐ Details: _____
Who do you currently live with? _____
Do you have children? Yes☐ No☐. If yes, how many children: _____ What is/are their age(s)? _____
Do you have custody/access of your children? Yes☐ No☐ Details: _____
Do you have a healthy relationship with each of your children? Yes☐ No☐ Details: _____
Who do you consider to be part of your support system:(family member/friend/other): _____
_____

## Mental Health

Have you been diagnosed with a mental health disorder? Yes☐ No☐ Unsure. If yes, please explain: _____

Have you ever been hospitalized for a mental illness? Yes☐ No☐. If so, when? _____

Are you currently taking any medications for your mental health?☐Yes☐No. Medications: _____

Is there any history of mental illness in your family? Details: _____

Are you concerned with your alcohol or substance use? Yes☐ No☐ Details: _____

Is anyone close to you concerned with your alcohol or substance use? Yes☐ No☐

Has anyone close to you died by suicide? Yes☐ No☐ If so, what was their relationship to you? _____

Are you experiencing thoughts of suicide? Yes☐ No☐ If so, how recent/often? _____

Have you engaged in self-harm behaviours? Yes☐ No☐. If yes, how often ☐Daily☐Weekly☐Monthly☐other

Have you had thoughts of harming others? Yes☐ No☐ If yes, ow often ☐Daily☐Weekly☐Monthly☐other

Has your mental health impacted your ability to participate in activities of daily living? Yes☐ No☐
If so, please explain:

## Present Situation

Are you employed Yes☐ No☐. If yes, what type of work do you do? _____

Is your job a source of stress? Yes☐ No☐ Details: _____

What is your main source of income: ☐employment ☐OW/ODSP/CPP ☐other: _____

Do you have access to Group Insurance Benefits or an EAP program that covers counselling/therapy costs? Yes☐ No☐

Have, or are you connected with any other community agencies, resources? Yes/No.
Please list: _____

Are you currently engaged in services with other professionals/ programs to support your mental health? Yes/ No.
Please list: (e.g.: psychologist/ psychiatrist / other mental health professional(s):

_____

## Counselling objectives

What brings you to counselling at this time? Describe the current problems as you see them: _____

_____

_____

How long have you been dealing with this? _____

_____

Have you experienced any recent significant life changes or stressful events? Yes☐ No☐. Details: _____

How have you managed to cope with difficult issues in the past? _____

What do you hope to gain from short term counselling? _____

Are you committed to attending individual therapy to work on self-identified goals? Yes☐ No☐ Unsure☐

## Preparing for the appointment

Is there a preferred day/time that works for you (between M-F 8-4:30)? _____

Please check if you prefer a counsellor that is ☐ male ☐female or ☐no preference. Details: _____

Have you received counseling with Rapids Family Health Team in the past? Yes☐ No☐

Have you received therapy/counseling outside of the Family Health Team? Yes☐ No☐

Where/when did you receive these services? _____

Would you like to share any cultural background details that would be helpful for the counsellor to know? _____

_____

Is there anything else that you feel is important or helpful for a counsellor to know? _____

_____

**Office Use Only: Date received**: _____