Rapids
Family Health Team

# Mental Health Intake Form

ATTENTION: Drop off completed forms to 1150 Pontiac Dr., Sarnia.

**Eligibility Checklist:** Note: Your information will be included in your chart.

☐ 16 years or older

☐ Used all EAP/Group Benefits before accessing RFHT counseling

☐ Doctor is part of a referral FHO Physician group

☐ Can attend counseling during these hours: Monday: 8:30 AM - 5:30 PM (phone/virtual after 4:30 PM) Tuesday to Thursday: 8:30 AM - 3:30 PM Friday: 8:30 AM - 11:00 AM

If you don't meet the parameters or have questions, contact our mental health intake worker at 519-339-8949, ext. 156.

## Personal Information

Date: _____ First name: _____ Last Name: _____

Preferred Name: _____ Preferred Pronoun: _____ Gender: _____

Date of Birth: _____ Age: _____Health Card Number #_____

Version code_____ Address: _____

Preferred contact number: _____ **Can a detailed voicemail message be left? Yes☐ No☐**

Email: _____ **Can a detailed email be left? Yes☐ No ☐**

Emergency contact: _____Relationship: _____ Emergency contact phone number: _____

Family Physician: _____Referral Source: ☐Self ☐other: _____

Is English your first language: Yes☐ No☐ If not, do you have a preferred language?

## Physical Health

Do you exercise regularly: Yes☐ No☐ infrequent☐ 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 | ☐Feeling hopeless |
| ☐Inability to feel joy | ☐Excessive Worry | ☐ Lack of motivation | ☐Poor Concentration |
| ☐Fatigue/loss of energy | ☐Changes in appetite | ☐ Memory impairment | ☐Substance misuse |
| ☐Panic attacks | ☐Easily startled | ☐ Delusions | ☐Hallucinations |
| ☐Increased irritability | ☐Easily angered | ☐ Dramatic mood swings | ☐Low mood |
| ☐Feeling detached/numb | ☐Intrusive thoughts | ☐ Intrusive memories | ☐Low self-esteem |

☐Trouble controlling emotions ☐ Feelings of guilt/blame/regret

☐Thoughts of harming others ☐ 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.

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.
Have you received counseling with Rapids Family Health Team in the past? Yes☐ No☐
If yes, who did you see? _____
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? If yes please explain:

_____