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

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

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:	Address:	Phone Number:
Specialty:		
Name:	Address:	Phone Number:
Specialty:		
Name:	Address:	Phone Number:
Specialty:		

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**
Father	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Mother	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Sibling 1 □ M □ F	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 2 □ M □ F	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 3 □ M □ F	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 4 □ M □ F	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 5 □ M □ F	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 6 □ M □ F	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

_____
_____
_____
_____
_____
_____
_____
_____

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 full session charge.

INTEGRATE HEALTH SERVICES TEAM APPROACH- CIRCLE OF CARE:

Integrate Health Services is a multi-disciplinary team working in partnership with 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 dependent upon the needs of the individual client(s). *When you access speech therapy services, please be aware that the information you provide to Integrate Health Services or Kids Clinic is shared with our partner Speech Therapy Centres of Canada. By signing this form, you are consenting to all services provided through Integrate Health Services or Kids Clinic, including those affiliated with Speech Therapy Centres of Canada and understand that the same limits of confidentiality apply.

Integrate Health Services provides the following additional programs and services:

- *Counselling Services*
- *Applied Behaviour Analysis/Intensive Behavioural Intervention*
- *Behaviour Consultation*
- *Child/Youth/Adolescent Group Programs*
- *Parent Support and Education*
- *Education Services*
- *Art Therapy*
- *Occupational Therapy*
- *Speech and Language Therapy (through partnership with Speech Therapy Centres of Canada)*
- *Naturopathic Services*
- *Medical Assessment and Treatment services (by referral only through partnership with Kids Clinic)*

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

INTEGRATE
HEALTH SERVICES

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