IN T A K E F O R M
for Dr. Douglas Ozier (R. Psych #2195)

Please and answer the questions below and bring this form to your first session.. If any of the questions are too difficult to answer feel free to leave them blank and we will discuss them in our meeting. Please note: information you provide here will be protected as confidential.

Name:

_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age:

_____
Address:

_____
(Street and Number)

_____
(City) (Province) (Zip)

Home Phone: ( ) May I leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May I email you?
□ Yes □ No

*Please note: Email correspondence is not considered to be a fully confidential medium of communication.

Referred by? How did you learn of my service?

Emergency contact name, Relationship, and Contact

Number:_____

Do you currently have a GP? □ Yes □ No

If so, name and contact:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, list previous therapist/practitioner, describe the nature of the services, and approximate dates:
_____
_____ _____
_____
_____ _____
_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____
_____ _____
_____
_____ _____
_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:
_____
_____ _____
_____
_____ _____
_____

Reasons for seeking counselling (please use point form to briefly list the main reasons you are seeking counselling at this time)

Personal History

Where did you grow up?

If you are not originally from the area, how long have you lived in the Lower Mainland?

How many people are in your family? What is your birth position?

Please use a few words to describe the overall quality in your home growing up?

Please use a few words to describe your mother as a person (if know) and a few words to describe your current relationship with her.

Please use a few words to describe your father as a person (if know) as a person and a few words to describe your current relationship with him.

If you have siblings, how often do currently contact them?

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle yes or no

List Family Member
Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no:

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list how many hours of sleep you typically are getting and describe any specific sleep problems you are currently experiencing:

___# of hours:
_____
___ _____
_____
_____ _____
_____

How many times per week do you generally exercise? _____
What types of exercise to you participate in?
_____ _____
_____
___ _____

Do you engage in any self care practices (e.g., yoga, meditation etc)?
□ No
□ Yes

If yes, which ones and how often?
_____
_____ _____
_____
_____ _____
_____

Please list any difficulties you experience with your appetite or eating patterns:
_____
_____ _____
_____
_____ _____
_____

Screening Questions for Current Functioning (please circle Y or N)

In the **past 2 weeks, on most days,** have you experienced:

Sadness most days **Y / N**

Lack of interest in previously enjoyed activities **Y / N**

Thoughts of suicide or self-harm **Y / N**

In the **past 6 months,** have you been:

Excessively worried about a number of different events or activities in your daily life? **Y / N**

What percent of the day (when awake) do you spend worrying? ____**%**

Does this worry cause significant distress or interfere with your social life, your job or schooling, or other important areas of functioning? **Y / N**

In the past month:
have you been bothered by recurrent thoughts, images or impulses that are unwanted, intrusive, and distressing? (For example, thoughts of germs; fear of accidentally harming someone; unwanted sexual or religious thoughts). **Y / N**

In the past month:
have you felt driven to repeat certain behaviours or mental rituals over and over to try to reduce your distress? (For example, washing or cleaning, checking, counting, arranging things, praying, repeating words or numbers in your head, hoarding items). **Y/ N**

Are you **currently** experiencing panic attacks (an intense rush of fear that can include feelings such as sudden rapid heart beat, feelings of suffocating, and/or fears of dying or going crazy)?
□ No
□ Yes
□ Maybe, not sure

Have you **ever** felt anxious in places or situations where you might have a panic attack , where help might not be available, or where escape might be difficult, so that you have avoided or wanted to avoid situations such as: leaving your house, being in a crowds, standing in a line, or traveling on buses/trains?: **Y / N**

Have you recently experienced fear or worry about doing things in front of other people (either formally or at social events), such as speaking, eating, or writing? **Y / N**

If so, do you believe your fear of social situations is excessive or unreasonable? **Y / N**

Have you **ever** had a period of at least several days when you were feeling so 'up' or 'high' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self?
(Do not consider times when you were intoxicated on drugs or alcohol.) **Y / N**

Have you **ever** had a period of at least several days when you felt persistently and unusually irritable, to the point that others noticed that you were irritable or over reacting, in a way that is out of character for you?
(Do not consider times when you were intoxicated on drugs or alcohol.) **Y / N**

Have you **ever** experienced , witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? **Y / N**

If so, during the **past month**, have you re-experienced the event in a distressing way(such as, dreams, intense recollections, flashbacks or physical reactions)? **Y / N**

Are you currently experiencing any chronic pain? **Y / N**

If yes, please describe:

_____
_____ _____
_____
_____ _____
_____

How often do you drink alcohol?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____
Do you have some close friends that you feel are there for you? Yes/No

How satisfied are you with your social life? 1-10 _____

How often do you go out socially?

How often would you like to go out?

Please list any significant life changes or stressful events have you experienced recently:
_____
_____ _____
_____
_____ _____
_____

Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?
_____

Do you enjoy your work? Is there anything stressful about your current work?
_____
_____ _____
_____
_____ _____
_____

Hopes for therapy (please describe in point form the 3 or 4 most important ways that your life will be different if counselling is successful)