

DR. JACQUELINE RYNARD
PSYCHOLOGICAL SERVICES
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BARRIE ONTARIO L4N 1L2

INTAKE FORM

Date: ____/____/____

First Name _____ Last Name _____

Date of Birth: _____ Age: _____ Gender (Circle One): Male Female

Relationship Status: _____

Who else is living in your home?: _____

Address _____ Apt # _____

City _____ Province _____ Postal Code _____

Primary Phone _(____)_____ Work Phone _(____)_____ Ext. _____

Cell Phone _(____)_____ Email Address _____

Currently employed? Yes No Type of employment? _____

Employer (optional) _____

Contact Person, in Case of Emergency _____

Relationship to you: _____ Phone: _(____)_____

How were you referred: _____

Have you had any previous mental health treatment: Yes No
If yes, please give details – when, where, How long, provider name, medications etc

Are you currently (or in the recent past) taking any prescription or over the counter medications?
 Yes No *If yes, please give details.*

Does anyone else in your family (blood relatives) experience any mental health difficulties?
 Yes No *If yes, please give details:*

Do you drink alcohol? Yes No
If yes, please give details – how much, how often, any blackouts, etc.

Do you use any other recreational drugs? Yes No
If yes, please give details – what drugs, how often, last use etc

Have you ever suffered from any type of eating disorder? Yes No
If yes, please give details:

Have you ever been charged with a crime, arrested or convicted? Yes No
If yes, please give details:

Do you have any work-related problems or difficulties in school? Yes No
If yes, please give details:

Do you have a history of trauma (any kind of abuse, neglect, victim of natural or other disaster etc)?
 Yes No *If yes, please give details:*

Do you experience any difficulties in your relationships with family, peers, or significant others (e.g. shyness, loneliness, conflict, etc.)? Yes No *If yes, please give details:*

Symptoms Checklist:

Sleep: No problems Not enough Trouble getting up Nightmares Too much sleep

Appetite: No problems No interest Increased appetite Carbohydrate craving

Energy: Normal Increased Low Up and down

Interest in Sex: Normal Increased Low

Concentration: Normal Somewhat difficult Poor Terrible

Memory: Good Some difficulty remembering Poor

Depressed or sad: All the time Most days Some days Not at all

Suicidal thoughts: All the time Most days Some days Not at all

Past suicidal attempts: No Yes

If yes, please give details:

Anxiety: Panic attacks All the time Most days Some days Not at all

Anger/Irritation: All the time Most days Some days Not at all

Check Any of the Following That May Apply to You:

- Headache
- Dizziness
- Fainting Spells
- No Appetite
- Over-Eating
- Stomach Trouble
- Bowel Disturbances
- Always Tired
- Always Sleepy
- Unable To Relax
- Insomnia
- Recurrent Dreams
- Nightmares
- Hallucinations

- Inferiority Feelings
- Feel Tense
- Feel Panicky
- Fears and Phobias
- Obsessions
- Depressed
- Suicidal Ideas
- Take Tranquilizers
- Alcoholism
- Dangerous Drugs
- Allergy
- Asthma
- Sexual Problems
- Other: _____

- Shy With People
- Can't Make Friends
- Afraid Of People
- Home Conditions Bad
- Unable To Have A Good Time
- Always Worried About Something
- Don't Like Weekends/Vacations
- Can't Make Decisions
- Over-Ambitious
- Financial Problems
- Gambling
- Job Problems
- Can't Keep A Job

What do you wish to achieve with therapy and /or an assessment? _____

Any other comments: _____

The information on this form will be kept confidential by Dr. Jacqueline Rynard