DR. JACQUELINE RYNARD
PSYCHOLOGICAL SERVICES
72 Ross Street, Suite 16
Barrie, Ontario L4N 1G3

INTAKE FORM

Date: _____/_____/_____

First Name ________________________________ Last Name ________________________________

Date of Birth:_____________________ Age:_______ Gender (Circle One): Male Female Other

Relationship Status:____

Who else is living in your home?:____

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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? ______________________________

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Any other comments: ____

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