Saluté Family Medicine

MENTAL HEALTH INTAKE FORM

All information contained in this form are strictly confidential and will become part of your medical record.

	Date of birth: (M/D/Y)
Alberta Health Care Number:	
Name (Last, First, M.I.):	**Sex (genetically)** ☐ M ☐ F **Preferred Pronouns**
CONTACT INFORMATION	
Address:	
City:	**Postal Code:**
Home Phone: **Business**:	**Cell:**
Preferred Contact Number:	
Email:	
Preferred Appointment Confirmation Method: ☐ Phone: _____ Safe to leave message? ☐ Yes ☐ No ☐ Email ☐ Text message	
Emergency Contact:	
Preferred Pharmacy:	

Please check that you have included your **Alberta Health Care Number**!

Submit your completed form to Saluté by one of the following options:

Email - admin@salutefamilymedicine.ca
Mail - #304, 1010 - 1 Avenue NE, Calgary AB T2E 7W7
Fax - 403-800-3055

7/2/2014

Original Date:
Dates Revised:

NEW PATIENT HEALTH QUESTIONNAIRE

Name (Last, First, M.I.): M F		**DOB:**
Marital status: Single Partnered/Married Divorced Widowed	**Spouse's Name:**	
Address:		
Phone numbers: (personal) (work)	**Email:**	
Occupation:		
Preferred Appointment Confirmation Method:		

What is your primary mental health concern?

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	Sedentary (No exercise)					
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Do you have any food intolerances?				Yes	No
	Are you vegetarian?				Yes	No
	What type?					
Caffeine	□ None	Coffee	Tea	Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				Yes	No
	If yes, what kind?					
	How many drinks per week?					
	In the last year, have you ever drank more than you intended to?				Yes	No
	Have you considered stopping?				Yes	No
	Have you ever experienced blackouts?				Yes	No

Tobacco	Do you use tobacco?				Yes	No
	Cigarettes – pks./day	Chew - #/day	Pipe - #/day	Cigars - #/day		
	# of years	Or year quit				
Drugs	Do you currently use recreational or street drugs?				Yes	No
	Have you ever given yourself street drugs with a needle?				Yes	No
Personal Safety	Do you live alone?				Yes	No
	Do you have frequent falls?				Yes	No
	Do you have vision or hearing loss?				Yes	No
	Do you have an Advance Directive and/or Living Will?				Yes	No
	Would you like information on the preparation of these?				Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				Yes	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	M F	
Mother				M F	
Sibling	M F			M F	
	M F			M F	
	M F		**Grandmother** Maternal		
	M F		**Grandfather** Maternal		
	M F		**Grandmother** Paternal		
	M F		**Grandfather** Paternal		

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No

7/2/2014

Have you ever been to a counselor?	Yes	No

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and will become part of your medical record.

Dropping it off at the clinic

We will then give you a call to set up an appointment for an Introductory Health Visit.