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Intake Questionnaire

Dear Client,

Welcome to Rewrite Wellness! In this packet, you will find a number of questionnaires that will help me to learn more about you and the challenges that you are facing. Please know that all information that you provide in this document is strictly confidential. Your privacy is of the utmost importance to me.

Completing this package as thoroughly and truthfully as possible will help to ensure that we generate a treatment plan that is best suited to your individual needs. Throughout the assessment, we will discuss goal-setting and what *you* are hoping to get out of therapy. You will have the opportunity to ask questions and to decide whether you feel that Rewrite Wellness is a good fit for you.

Limits to Confidentiality

All of the information that you provide to us, whether verbal, written, or on tape, is considered confidential by law and by the ethical principles of the College of Registered Psychotherapists of Ontario (CRPO). This means that if you are over the age of 18, information *cannot* be given out to other parties without your written permission. No information that is disclosed during therapy will be shared outside of the session, **with three exceptions**. If I feel that there is a risk of you harming yourself or someone else, if I believe that there is a child/minor in need of protection, or if records are subpoenaed by the court system, I have an ethical and legal duty to break the confidentiality agreement and inform the proper authorities. ***A more thorough explanation of limits to confidentiality can be found in a document in the "Forms" tab on my website.***

Cancellation Policy:

If you must cancel an appointment for any reason, I ask that you provide **24 hours notice**, or you may be charged the full session fee. Exceptions will be made for emergencies and/or serious/contagious illness. Cancellations may be made via phone, text, or email.

Please sign below to indicate that you have read and agree with the above information and consent to the policies described above:

_____ _____

Client's Signature Date

Section 1: Basic Personal Information

Name: _____
(Last) (First) (Middle Initial)

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

Marital Status:

Single Living with Partner Widowed

Married Divorced or Separated Other

Please list any children/age: _____

Address: _____
(Street and Number)
_____
(City) (Province) (Postal Code)

Home Phone: (____)_____ May we leave a message? Yes No

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

E-mail: _____ May we email you? Yes No

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

Referred by (if any): _____

Employment Status:

Not Working Full-time Student

Part-time On disability Retired

What is your occupation (if applicable)? _____

What is your highest educational level?

Ph.D., MD, or equivalent BA, BS, or equivalent

MA, MS, or equivalent Some college/university

Some Graduate School Some high school

<u>Emergency Contact Person:</u>

Name:_____

Relationship to you:_____

Phone Number(s): _____

Section 2: Current Problem(s)

Please describe the key problems for which you are currently seeking treatment, and when they began. Please feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

_____

_____

_____

_____

_____

_____

SCREENING QUESTIONNAIRE

This form will ask you about problems that you may have had. Please respond to each question by circling "Yes," "No," or "Maybe/Unsure."

	CIRCLE ONE:		
1. Do you have times when you feel a sudden rush of intense fear or discomfort?	YES	NO	MAYBE/UNSURE
2. Do you feel panicky in any situations or avoid them because you might feel panicky?	YES	NO	MAYBE/UNSURE
3. Are you apprehensive about entering situations due to the fear that you may develop such symptoms as diarrhea, vomiting, dizziness, etc.?	YES	NO	MAYBE/UNSURE
4. In social situations where you might be observed or evaluated by others or when you are meeting new people, do you feel fearful, anxious, or nervous?	YES	NO	MAYBE/UNSURE
5. Are you overly concerned that you may do and/or say something that might embarrass or humiliate yourself in front of others, or that others may think badly of you?	YES	NO	MAYBE/UNSURE
6. Over the last several months, have you been continually worried or anxious about a number of events or activities in your daily life?	YES	NO	MAYBE/UNSURE
7. Are you bothered by thoughts, images, or impulses that keep recurring to you that seem inappropriate or nonsensical but that you can't stop from coming into your mind?	YES	NO	MAYBE/UNSURE
8. Do you feel driven to repeat some behavior	YES	NO	MAYBE/UNSURE

or to repeat something in your mind over and over again to try to feel less uncomfortable?

9. Do you fear or feel a need to avoid such things as flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects? YES NO MAYBE/UNSURE
10. Have you ever experienced or witnessed a traumatic or life-threatening event? YES NO MAYBE/UNSURE
11. Have you ever experienced a period of two weeks or more when you felt depressed, sad, empty, or lost interest or pleasure in your usual activities? YES NO MAYBE/UNSURE
12. Over the past two years, have you frequently had days where you felt down, blue, or depressed for most of the day? YES NO MAYBE/UNSURE
13. Have you ever experienced a period of several days or more when you felt unusually or excessively high or irritable? YES NO MAYBE/UNSURE
14. Over the last several months, have you continually feared or believed that you might have a serious physical disease or illness? YES NO MAYBE/UNSURE
15. Have you had a lot of health problems in your life? YES NO MAYBE/UNSURE
16. Do you often have days when you feel somewhat down or depressed or maybe anxious or keyed up? YES NO MAYBE/UNSURE
17. Has there ever been a period of time when you drank too much alcohol? YES NO MAYBE/UNSURE
18. Do you drink a large amount of beverages that contain caffeine? YES NO MAYBE/UNSURE
19. Have you ever used any other substances such as marijuana or cocaine? YES NO MAYBE/UNSURE
20. Have you ever experienced a loss or change in your physical functioning such as paralysis, seizures, or severe pain? YES NO MAYBE/UNSURE
21. Has there ever been a period of time when you had strange or unusual experiences such as hearing or seeing things that other people didn't notice, hearing voices when no one was around, or seeing visions that no one else saw? YES NO MAYBE/UNSURE
22. Has there ever been a time when you felt like something odd was going on around you and that you had to be hypervigilant? YES NO MAYBE/UNSURE

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to the symptom.

	NOT AT ALL **(0)**	**MILDLY** It did not bother me much **(1)**	**MODERATELY** It was very unpleasant, but I could stand it **(2)**	**SEVERELY** I could barely stand it **(3)**
1. Numbness or tingling				
2. Feeling hot				
3. Wobbliness in legs				
4. Unable to relax				
5. Fear of the worst happening				
6. Dizzy or lightheaded				
7. Heart pounding or racing				
8. Unsteady				
9. Terrified				
10. Nervous				
11. Feelings of chocking				
12. Hands trembling				
13. Shaky				
14. Fear of losing control				
15. Difficulty breathing				
16. Fear of dying				
17. Scared				
18. Indigestion/discomfort in abdomen				
19. Faint				
20. Face flushed				
21. Sweating (not due to heat)				
Column Totals				

Please total each column and record the score in the bottom row. Then, please find *the sum of all*

***scores* and record it here: _____.**

Patient Health Questionnaire – PHQ -9

1. *Over the last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.				
g. Trouble concentrating on things, such as reading the newspaper or watching TV				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Total Score: _____

What are some of your currently used coping strategies for dealing with stress, anxiety, depression, or any other negative emotion?

_____

_____

_____

Section 3: Psychological Treatment History

Have you ever received any treatment for mental health in the past? If so, who did you see, and for what reason?

_____

_____

_____

Section 4: Medical History

Please *very briefly* describe your current physical health:

_____

_____

_____

Please *very briefly* describe any significant past medical problems and treatments (i.e., surgeries):

_____

_____

_____

Please record any medications that you have been prescribed and note the purpose below:

_____

_____

Section 5: Social History

Please circle below to indicate your typical substance use (i.e., alcoholic beverages and/or drugs, including marijuana). ***Remember that all information that you provide is strictly confidential.***

I use substances:

Never Occasionally Nearly Every Day Every Day

Please record all substances that you use in the space below:

_____

_____

_____

This can be difficult to discuss, but have you had any traumatic experiences throughout your life? Traumatic events can include: abuse (physical, sexual, and/or emotional), witnessing violence, being a victim of violence, being in an accident, *witnessing* a traumatic event*, etc*. **If it is too difficult to share/specify the nature of the incident, please simply write "yes" or "no" in the blank below to indicate whether you have experienced any trauma.**

_____

_____

_____

_____

Finally, is there anything else that you think would be important for me to know about you or your history?

_____

_____

_____

_____

_____.

Thank you SO MUCH for taking the time to complete the Rewrite Wellness Intake Package. I look forward to working with you and helping you to write the next chapters of your story!