CLIENT INTAKE FORM

Whole Heart Wellness Mental Health Clinic
1739 Bathurst Street, Toronto

These questions are designed to help us begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

General Info

Referred by:
Medical Provider: _____
Insurance Provider: _____
Full Name: _____
Date of Birth: _____
Address: _____
Contact numbers: _____ may we leave message ____
Email: _____ may we email you _____
Please note: Email correspondence is not considered to be a confidential medium of communication
Emergency contact: _____
Legal Guardian: _____
School: _____ Grade: _____
Other school info: _____

How did you hear about us? Please check mark
Our Website: ☐
Friend/Family ☐
Other: _____

The Mind

Have you previously received any type of mental health services?
Yes ☐
No ☐
If yes, which of the following:
☐ Psychotherapy
☐ Medication
☐ Outpatient Hospitalizations
☐ Inpatient Hospitalization
☐ If yes, please provide:
Name of provider or facility:_____
Location:_____Dates of treatment:_____
Reason for treatment:_____

Briefly, what brings you in today? _____
_____
_____

When did the problems first start? Within the last:
☐ 30 days

 6--12 months
 2 years or more
What areas of your life have been affected because of this problem?
_____
_____
_____

Are you currently experiencing overwhelming sadness, grief or depression?
 Yes
 No
If yes, for approximately how long? _____
Are you currently experiencing anxiety, panic attacks or have any phobias?
Yes
 No
If yes, when did you begin experiencing this? _____
What significant life changes or stressful events have you experienced recently?
_____
_____
_____
What would you like to accomplish out of your time in therapy?
_____
_____
_____

Family History

Any challenges during your mother's pregnancy of you?
 no
 yes, comment:
_____
_____
Did you progress without major difficulty through your developmental milestones?
 yes
 no, comment:
_____
_____

Please list the member's of your family
(Name, Age, Relationship to you, Where do they live now? If deceased, age and cause of death)

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.
Condition Please circle List Family Member
Alcohol/Substance Abuse yes/no
Anxiety yes/no

Depression yes/no
Eating Disorders yes/no
Obsessive Compulsive Disorder yes/no
Schizophrenia yes/no
Suicide Attempts yes/no
Personality Disorders
Other diagnosed mental health condition? yes/no : which was---

The Body

How would you rate your current physical health?
 Poor
 Unsatisfactory
 Satisfactory
 Good
 Very Good
Please list any specific health problems you are currently experiencing:
_____
_____
_____

Please indicate if applicable, Medication/Supplement Dosage and duration:
Include prescribing provider
_____
_____
_____
_____

How would you rate your current sleeping habits?
 Poor
 Unsatisfactory
 Satisfactory
 Good
 Very Good
If you are having problems, in which phase of sleep are you experiencing issues?
 Falling asleep
 Staying asleep
 Awakening early
 Sleep apnea
How many hours of sleep do you on average get?
 2-4
 5-7
 8-10
Please list any other specific sleep disturbances you are currently experiencing
_____

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

How would you rate your eating habits?
 Poor
 Unsatisfactory
 Satisfactory

□ Good
□ Very Good
Please describe briefly any challenges you are experiencing with your eating habits.
_____
_____

Please describe current or past use of alcohol, cigarettes, and/or recreational drugs:
_____
_____
_____
_____
_____

The Spirit

What do you enjoy most?
_____
_____

How do you self-care?
_____
_____

What are your future aspirations?
_____
_____

What do you value the most and or what beliefs/faith do you hold?
_____
_____
_____
What you consider to be your strengths?
_____
_____
_____