**ADULT INTAKE FORM** (for couples each member should fill out their own form)

Date:_________________

**CONFIDENTIAL AND PRIVILEGED INFORMATION**

Please print. Answer all questions as well as you can. **Your completion of this questionnaire will help decrease the time needed to make an accurate evaluation of your needs, as well as help to focus attention to your most relevant concerns.** If you do not understand any of the questions, please feel free to call our office at 778.998-7975.

Client's name: ________________________________________ Date: __________________

Address: ____________________________________________________________________

City, State: _____________________________________________ Zip: _________________

Phone numbers ***with area code*** Home: (      )____________________

Work: (     )________________          Cell: (      )__________________

Birth date: _________________ Age: ____

Employer: ____________________________________________________________________

Education: ___________________________________________________________________

Marital/relationship status: ______________ Significant other's name: _________________

Significant other's age and sex: ___________ How long together? ____________________

Names and ages of all children in the home: ______________________________________

How did you hear about Dr. Roche?_____________________________________ * use reverse side if necessary

Who shall we contact in case of emergency?

Name: _________________________________________Phone (    )_____________

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In this box, please indicate the address and telephone number you want us to use to when sending bills or when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above.

If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you by phone:

Is there an email address you feel is secure and we may use to contact you? If so list it below. Be aware, emails are not a secure communication method:

I hereby consent for Dr. Jim Roche to provide evaluation and treatment to me.

______________________________________________________________________

Signature Date

------------------------------------------------------------------------------------------------------------------------

Dr. Roche Signature ____________________________________________________

Date

Dr. Roche Informed Consent Statement:

______________________________________________________________________

______________________________________________________________________

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## Medical and Health History

Name:__________________________________________ Date:______________________

List any allergies you have: _________________________________________ None_____

Primary Care Physician: ________________________Address:______________________

City:________________________________ Prov.:____________ Postal Code:_____________

Primary Care Physician's phone number: (____) ________________________________

Date of your most recent physical examination:__________________________________

**Please list all current medications and dosages:**

| Name of Medication | Dosage | Name of Prescribing Doctor | When did you start taking it? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list all current or past health problems, and any major operations:**

| Current | Past |
|---|---|
| | |
| | |
| | |
| | |

List all therapists you have seen, and dates you saw them: __________________________

___________________________________________________________________________

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List any substance abuse treatment or inpatient psychiatric treatment you have had, and the

dates:______________________________________________________________

**Please indicate which of these substances you currently use:**

| Substance | Amount used | How often? |
|---|---|---|
| Cigarettes | | |
| Alcohol | | |
| Pills not prescribed for me | | |
| Marijuana | | |
| Cocaine or crack | | |
| LSD | | |
| Heroin | | |
| Other (please list): | | |

**What kind of problem brings you to Counseling ?**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Please indicate if you are having any of the following problems, or if you had them in the past:**

| | I have this now | I had it in the past |
|---|---|---|
| Difficulty falling asleep or staying asleep | ______ | ______ |
| Sleeping too much | ______ | ______ |
| Change in appetite, weight loss, or weight gain | ______ | ______ |
| Frequent crying | ______ | ______ |
| Panic attacks or anxiety attacks | ______ | ______ |
| Thoughts of killing or hurting myself | ______ | ______ |
| Attempts to kill or hurt myself | ______ | ______ |
| Problems concentrating | ______ | ______ |
| Problems remembering things | ______ | ______ |
| Periods of daily sadness lasting more than two week | ______ | ______ |
| I startle easily | ______ | ______ |
| Can’t stop remembering upsetting past events | ______ | ______ |
| Difficulty controlling my temper | ______ | ______ |
| I physically hurt other people | ______ | ______ |
| I break things sometimes | ______ | ______ |
| I worry a lot | ______ | ______ |
| Little or no interest in sex | ______ | ______ |
| I feel tired almost every day | ______ | ______ |

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Feelings of unreality ______ ______
Made myself throw up in order to lose weight ______ ______
Used laxatives or exercised excessively to lose weight ______ ______
I often feel like I am an outsider ______ ______
Sexual problems ______ ______
Worry that something is wrong with my body ______ ______
Frequent arguments with the people I live with ______ ______
I hear voices inside my head ______ ______
Other (please list):

______________________________________________________________________

______________________________________________________________________

______________________________________________ ____________________
Signature Date

Do Note Write Below This Line
--------------------------------------------------------------------------------------------------------------------

Dr. Roche / Notes:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Dr. James Roche, Reg Psych Main Office Address 9304A Salish Court, Burnaby, British Columbia V3J 7J8