INTAKE QUESTIONNAIRE

CLIENT INFORMATION:

Date: _____

Name: _____

Address: _____

Telephone Numbers (day) _____ (evening) _____
Can messages be left at day number? _____ Can messages be left at evening number? _____

Date of Birth: _____ Age: _____

Referred by: Name _____
Address & Telephone _____

Are you involved with the Workplace Safety and Insurance Board (WSIB) as a result of your injury/illness? Yes ___ No ___
If yes, please indicate: a) your claim number _____
b) name of your nurse case manager
_____

Are you involved with your automobile insurance company as a result of your injury/illness? Yes ___ No ___
If yes, please indicate:
a) date of accident _____
b) your insurance policy/claim number _____
c) name of your insurance company and adjuster _____

Do you have a legal representative? Yes ___ No ___
If yes, please indicate name of lawyer, business address, and telephone number:
_____

Family Physician: Name _____
Address & Telephone _____

Emergency Contact Person: Name _____ Address _____
Telephone (Day) _____ (Evening) _____

CURRENT DIFFICULTIES RELATED TO INJURY/ILLNESS:

Please indicate the reason that you are seeking services at this time. Describe the nature of your injury/illness including summary of what happened, nature of physical and emotional difficulties, and how long symptoms have been present:

_____
_____
_____
_____
_____

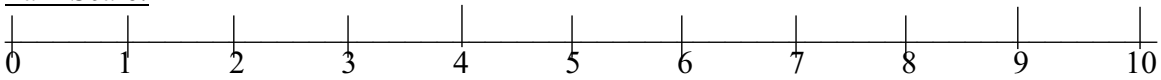
Please check the severity of your difficulties:
__ mildly upsetting __ moderately upsetting __ severe __ very severe __ extremely severe

What tests have you received regarding your injury/illness (e.g. MRI, CT, x-ray)?

_____

Have you been given a diagnosis regarding your injury/illness? Yes ___ No ___
If yes, please indicate the diagnosis: _____

Pain Scale:



0 no pain 1-2 mild 3-4 moderate 5-6 severe 7-8 very intense 9-10 excruciating

Using the pain scale, please indicate the degree to which you generally experience pain:
on a daily basis: _____
on a good day: _____
on a bad day: _____

Please describe where you experience pain and the nature of this pain (e.g. throbbing, burning, tingling, aching): _____
_____

What brings the pain on? _____
What makes the pain better? _____
What makes the pain worse? _____

Please indicate the name(s), title(s), address(es), and telephone number(s) of professionals you have consulted about your injury/illness: _____
_____
_____

What treatment(s) (e.g. surgery, physiotherapy, massage therapy, TENS, chiropractic) have you tried to help manage your pain? _____

Are you taking any medication to help manage your pain? If yes, please indicate the name, how much, how frequently, and with what results? _____

_____

What other ways do you try to manage the pain?

___ relaxation ___ tell myself I can handle this ___ apply heat/ice
___ distract myself ___ rest or lie down ___ talk to others
___ exercise ___ take non-prescription medication ___ other: _____

How well do you feel you are able to control the pain?

__cannot control __minimal control __some control __often able to control __control very well

To what extent has the pain interfered with your day to day functioning?

___completely interferes ___ interferes in many ways ___ interferes somewhat
___ interferes a little ___ minimally interferes

Please indicate what areas of your life are affected by the pain and provide examples:

___ emotional well-being E.g. _____
___ self-care tasks E.g. _____
___ household chores E.g. _____
___ child care E.g. _____
___ work/school E.g. _____
___ exercise/activity level E.g. _____
___ sleep E.g. _____
___ friends/social activities E.g. _____
___ community E.g. _____

Check off all that currently apply to you:

___ difficulties controlling pain
___ marital problems
___ family problems
___ relationship problems
___ legal problems
___ financial problems
___ work/school problems
___ sexual problems
___ depression
___ low self-esteem
___ guilt
___ hopelessness
___ suicidal thoughts
___ social isolation/withdrawal
___ loss/grief issues
___ anxiety/panic
___ fears/phobias
___ abuse issues
___ anger/frustration
___ easily agitated/annoyed
___ appetite/eating problems
___ sleep problems
___ low energy/fatigue
___ physical illness
___ concentration problems
___ confusion
___ memory problems
___ obsessions
___ compulsive or excessive behaviours
___ alcohol/drug problems
___ medication problems
___ unpleasant thoughts or dreams
___ difficulties controlling impulses
___ Other problems: _____

___ trauma issues _____

What are major stresses you are facing at this time? _____

_____

What do you wish to accomplish from psychotherapy? _____

_____

What behaviours or situations would you like to change? _____

_____

What feelings do you wish to alter (e.g. increase or decrease)? _____

_____

Have you ever received counselling/treatment/hospitalization for emotional difficulties?
Yes ___ No ___ If yes, please describe when and reasons for previous treatment:

_____

_____

Have you ever received medication for emotional difficulties? Yes ___ No ___
If yes, please describe the name, how much, how frequently, and with what results:

_____

_____

PERSONAL HISTORY:

Please list any other medical and/or health difficulties you are currently experiencing:

_____

_____

Please list previous injuries/illnesses: _____

Please list any family history of illness: _____

_____

Please list any family history of emotional difficulties: _____

_____

Do you drink alcohol? Yes ___ No ____
If yes, please indicate what kind of alcohol, how much, and how often (e.g. beer, 3 times/week):

_____

Do you use any non-prescription or other substances? Yes ___ No ____
If yes, please indicate what substance(s), how much, and how often:

_____

_____

Do you ever use alcohol or other substances to help manage your pain? Yes ___ No ____
Have you experienced any life events that were particularly distressing or traumatic for you?
Yes ___ No ____
If yes, please describe: _____

Please describe the nature of your friendships with others (e.g. number of friends, closeness of your relationships): _____
_____

Please describe the extent to which:
a) you feel comfortable trusting and confiding in others _____
b) you feel supported and understood by others_____

How do you generally cope with stressful or upsetting circumstances (e.g. distract myself, talk to myself, seek support, think the worst of things, keep to myself, try to escape, drink, keep busy)?
_____
_____

What are current interests, activities, or hobbies you enjoy? _____
_____

FAMILY INFORMATION:

Where were you born? _____ Where did you grow up? _____

Who did you live with during your childhood? _____

Please describe your childhood and the atmosphere in your home: _____
_____
_____

Please give a short description of your relationship with your mother and/or father:
Past: _____
_____
Present: _____
_____

If your mother is alive, what is her present age? _____
If your mother is deceased, what was the cause of death? What was your age at the time of her death? _____

If your father is alive, what is his present age? _____
If your father is deceased, what was the cause of death? What was your age at the time of his death? _____

How many brothers and sisters do you have? _____
Please list their gender and ages: _____
_____

Please give a short description of your relationship with your brothers and sisters:
Past: _____
_____
Present: _____
_____

Please list your current relationship status:
___Single ___Married ___Committed Relationship ___Separated ___Divorced ___Widowed

If you are in a relationship, how long have you been together? _____

Please describe your relationship including strengths and areas of concern: _____
_____
_____

In what ways has your partner been supportive of your injury/illness (e.g. assists with chores, pushes you to get out)? In what ways have you not felt supported? _____
_____

Briefly describe any significant past relationships: _____
_____

How many children do you have? _____
Please list their gender and ages: _____
_____

Please describe your relationship with your children including strengths and areas of concern:
_____
_____

Who currently lives with you? _____

EDUCATIONAL & OCCUPATIONAL HISTORY

Education (highest grade/level completed):
_____
Did you experience any difficulties in school? Yes ___ No ___
If yes, please describe: _____

Are you currently employed? Yes ___ No ____
If you are not working, is this due to your injury/illness? Yes ___ No ____

If you are currently working, please describe nature of your occupation and how long you have been working there: _____
Has your injury/illness affected your work? Yes ___ No ____
If yes, please describe: _____
What do you find satisfying about your present occupation? _____
In what ways are you dissatisfied by your present occupation? _____

SELF-DESCRIPTION:

Please describe your strengths: _____
Please describe what bothers you about yourself: _____

OTHER:

Please add any information not brought up by this questionnaire that may aid your psychologist in understanding and helping you.

_____
_____
_____
_____