LAURA LEE COPELAND, MD, MBA, FACEP

Get Well Clinic
649 Sheppard Ave West
Toronto, ON, M3H 2S4
Phone: 416-508-5691

Intake Form

Today's date:

First Name:

Last Name:

Date of Birth (Day/Month/Year):

OHIP # (including version code):

Gender:

What is your Sexual Orientation?

What is your relationship status?

Do you have children, if so, please provide the age and sex of each child:

Contact Information:

Address:

Phone Numbers:

Can I leave a message on your phone?

Emergency contact name:

Relationship of emergency contact:

Telephone for emergency contact:

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Referral Information:

Who referred you for therapy?

Name and address of family physician:

Name and address of psychiatrist:

Reason for Referral:

Personal information:

Sources of Emotional Support:

Spirituality/Religion:

What is your highest level of education?

Education History:

Employment History:

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History of Current Area of Concern:

What is the area of concern for which you are seeing me?

Impact of current area of concern to daily activities (getting dressed, feeding yourself, managing your finances, maintaining your living space):

Current stressors or life situations making you feel worse:

What hobbies, self-care or restorative activities do you enjoy?

Medical History:

Past Medical History:

Past Surgical History:

What current medication are you taking?

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Do you have allergies? If so, please list.

Are you currently misusing, or have you ever misused alcohol, street drugs or prescription drugs? If so, please elaborate (How often, How much per day etc):

Mental Health History:

Have you ever received a formal psychiatric diagnosis? If yes, what?

Have you ever been hospitalized and if so, what were the reasons? (please list dates, diagnoses, treatments, medications)

Have you ever attempted suicide or other self-harm? If so, when?

Tell me about any family medical and mental health or substance abuse history:

Do you have a history of trauma? Please describe to the extent you feel comfortable. Does it currently have an impact on your life, and if yes, how? Have you ever been treated for it?

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What is your prior experience with therapy? Please include with whom, when and what type of therapy:

Have you ever had a panic attack (sudden episodes of intense fear associated with a feeling of impending doom)? If yes, please elaborate:

Do you experience significant social anxiety (intense fear or avoidance of meeting or interacting with people due to fear of being negatively judged by them) in a way that interferes with your life? If yes, please elaborate:

Do you have specific fears that interfere with your life?

Do you think that you worry excessively?

In the past year have you often felt depressed, down, have little interest or pleasure in doing things or feelings of hopelessness? If so, please elaborate:

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Have you ever experienced long periods of time with elevated mood and or sleeplessness without fatigue, sometimes associated with behaviour you later regret? If so, please elaborate:

Are you experiencing any suicidal or homicidal thoughts, intentions or plans? Please describe.

Have you ever heard voices that other people cannot hear?

If yes, do they ever command you to do things such as hurt yourself or other people?

Have you ever felt that your thoughts were being read or taken over by other people or were being stolen out of your mind?

Have you ever felt that someone or something was trying to communicate directly with you by sending special signs or signals?

Have you ever felt that there was a plot going on to harm you or to have people follow you that your family and friends did not believe was true?

Do you have any special powers that most people lack?

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Personal Goals:

What are your personal goals for therapy?

How will you know when your personal goals have been achieved?

If you achieve your personal goals, how would your life look in the next year and what would you be doing?