



Initial Consultation Form

Full Name:

.....

Date of Birth: (yyyy-mm-dd)

.....

Email:

.....

Phone Number: (indicate home, office or mobile)

.....

Home Address:

.....

OHIP Number

.....

Private Health Insurance Information (if any)

.....

Emergency Contact Name and relationship:

.....

Emergency Contact Phone Number:

.....

Reason for Consultation:

- I need health advice to better manage a chronic health condition
- I need help with a mental health problem
- I need help with an addiction problem
- I need help to support someone else who has an addiction and or a mental health problem
- I think I might have ADHD
- I think my child might have ADHD
- I have some questions about my sexual orientation
- My child just came out to me and I need help dealing with the news
- I need help supporting an aging parent or a spouse with a deteriorating health condition
- I need help getting ready to welcome home a sick relative
- I need help to deal with multiple stressors in my life
- Other(specify)

History of Presenting Illness (HPI) (tell me a bit about why you are consulting)

Allergies: Please include prescription medications (Rx), over the counter (OTC) medications, foods and environmental

Past Medical History:

	Yes	No	Not sure
Do you have a primary care provider? (Family Doctor or Nurse Practitioner)			
Do you suffer from a chronic medical condition?			
Are you currently receiving treatment for a medical condition?			
Have you had a physical exam in the last year?			
Have you ever had any surgeries?			
Have you ever been in an accident?			
Have you ever been in, or witnessed a traumatic event?			
Have you received your childhood immunizations?			
Have you been immunized for Hepatitis A?			
Have you been immunized for Hepatitis B?			
Have you been immunized from pneumonia?			
Have you been immunized against influenza this year?			
Have you been immunized against influenza in the past?			
Have you received a booster against tetanus in the last 10 years?			

Medications: (include Rx medications, OTC medications, supplements, etc.)

Past Psychiatric History:

	Yes	No	Not sure
Have you ever been diagnosed with a mental health illness such as an anxiety disorder, depression, bipolar disorder, schizophrenia, etc?			
Have you ever been admitted to hospital for a mental illness?			
Have you ever received treatment for a mental illness?			
Have you ever taken medication for a mental illness?			
Do you currently take medications for a mental illness?			
Do you currently see a mental health provider as part of your mental health care plan?			
Have you ever attempted suicide?			
Do you currently feel suicidal?			

Substance Use History:

For all the substance listed below indicate:

1st use: How old were you when you first use it ?

Current use : How much, on an average do you consume (i.e cig/day, standard drinks per day, g/day)

What route: If you have ingested, inhaled or injected

Past best: How much were you using when you were most in control, feeling your best?

Past worse: How much were you using when you were at your worst?

How long without: If and when you quit, what is the longest amount of time you managed before relapse?

Last used: When did you use this last?

*OTC means meds accessible over the counter at a drug store without a prescription, ex: Gravol, Benadryl, Advil, Tylenol, decongestants, etc.)

Substance	1 st use	current use	what route	past best	past worst	how long without	Last used
cigarette / tobacco							
alcohol							
marijuana / hashish							
crack							
cocaine							
heroin							
benzos							
opioids							
hallucinogens							
Other Rx							
OTC *							
Other							

	Yes	No	Not sure
Do you ever need to take one of the substances to keep from being sick?			
Do you ever take one substance to help you deal with the effects of another?			
In your opinion are you currently experiencing withdrawal symptoms?			
Has your use increased in an attempt to get the same benefits?			
Is the time you spent acquiring, using and recovering from your substance use affecting negatively:			
Your work/school life?			
Your home life?			
Your social life?			
Are you experiencing legal problems?			
Do you have pending court dates?			