DR. JULIANNA SWITAJ PSYCHOLOGICAL SERVICES
ADULT INTAKE FORM

ALL INFORMATION YOU ARE PROVIDING IS <u>STRICTLY CONFIDENTIAL</u>

CONTACT INFORMATION

NAME_____ **DATE** _____

BIRTH DATE _____(day/month/year) AGE _____ GENDER _____

ADDRESS _____

_____ POSTAL CODE _____

□ HOME PHONE _____ □ CELL _____

□ WORK _____ EMAIL_____

- ✓ **PLEASE INDICATE WITH A CHECK MARK AT WHICH NUMBER(S)/MAIL WE MAY LEAVE MESSAGES**
- ✓ **IS IT OKAY TO USE YOUR EMAIL ADDRESS TO CONTACT YOU? NO_____ YES _____**

PERSONAL INFORMATION

EMPLOYER _____ POSITION _____

MARITAL STATUS _____ CHILDREN (names/ages)_____

_____

MEDICAL/PSYCH HISTORY

RELEVANT MEDICAL ISSUES _____

CURRENT MEDICATIONS & DOSAGES _____

FOR HOW LONG? _____

Family Physician _____ Phone _____

Have you had previous counselling/therapy? NO _____ YES _____

PLEASE COMPLETE THE REVERSE SIDE

If YES, for what period of time? _____

How long ago? _____

What was the result?(*i.e., very helpful, not helpful, "didn't work", etc.)* _____

_____

Are you here for the same issue? NO _____ YES _____ MAYBE _____

Please indicate your referral source:

_____ Family physician
_____ Lawyer
_____ Insurance Company
_____ WSIB
_____ Friend
_____ Internet
_____ Other

Would you like feedback to be provided to your physician ☐ Yes ☐ No ☐ Undecided

EMERGENCY CONTACT

Person to contact in an emergency _____

Phone number(s) _____Relationship _____

PLEASE NOTE
INFORMATION CAN <u>ONLY</u> BE TRANSMITTED OUT OF THIS OFFICE
WITH YOUR WRITTEN APPROVAL

_____

FOR OFFICE PURPOSE ONLY:

Printed information: _____ Cancellation Policy: _____ Quoted Fee: _____
Limits of Confidentiality discussed: _____ Privacy Policy info provided _____
WSIB _____ HCAI _____ Legal case pending _____ Direct billing to insurer: _____
Assessment only _____ Assessment/Treatment Planning _____ IME _____

Formal measures: _____
_____
_____

NOTES: