GENESIS CONSULTING PSYCHOLOGISTS

Philip J. McMahon Psy.D (psychotherapy), D.min (couns), M.S. (psych), C.Psych.
Clinical-Forensic Psychologist
http://www.barrhavenpsychologist.com
2301 BLUE ASTER St., OTTAWA, ONTARIO, K2J0X1
Cell: (613) 889-1720
Ontario Lic. #4939

ADULT INTAKE PACKET

Today's date: _____/_____/_____

Name: _____

Date of Birth: _____/_____/_____ Age: _____

Address:_____

City: _____ Prov:_____ Post Code:_____

E-mail:_____

Cell: (_____)_____ Home: (_____)_____

Work: (_____)_____

Occupation: _____

Employer: _____

Education:_____

_____

_____

If applicable, religious denomination:

_____

Emergency contact: _____

Relationship to you: _____

Cell: (_____)_____ Home: (_____)_____

Work: (_____)_____

Relationship status: (Circle One)

Single / Cohabiting/ Married / Separated / Divorced / Widowed

Spouse/Partner (Provide Name & Age): _____
Occupation: _____

Children (Provide Names & Ages):

_____

_____

Referred by:

_____

_____

Are you currently in treatment with another therapist? (Circle one) Yes / No

If yes, please list your therapist's name:

_____

Have you ever been in therapy in the past? (Please provide names & dates of previous therapists):

Name: _____

Dates: _____/_____/_____ to _____/_____/_____

Name: _____

Dates: _____/_____/_____ to _____/_____/_____

Are you currently taking medication for a psychiatric problem? (Circle one) Yes / No

If yes, please list the name, address, and telephone number of your prescribing psychiatrist:

Address:_____

City: _____ Prov:_____ Post Code:_____

Office: (_____)_____ E-mail:_____

If yes, please list the names, dosage, & dates of each of your medications:

Rx Name: _____
Dosage:_____mg Start Date: _____/_____/_____

Rx Name: _____
Dosage:_____mg Start Date: _____/_____/_____

Rx Name: _____
Dosage:_____mg Start Date: _____/_____/_____

Have you ever taken medication for a psychiatric problem? (Circle one) Yes / No

If yes, please list names, dosage and approximate dates you took the medication.

Rx Name: _____ Dosage:_____mg
Dates: _____/_____/_____ to _____/_____/_____

Rx Name: _____ Dosage:_____mg
Dates: _____/_____/_____ to _____/_____/_____

Rx Name: _____ Dosage:_____mg
Dates: _____/_____/_____ to _____/_____/_____

Have you ever been hospitalized for a psychiatric problem? (Circle one) Yes / No

If yes, please list the hospital, dates, and reason: _____

_____

When was the last time you had a physical examination by a doctor, and what was the outcome? _____

Physician Name: _____

Office: (_____)_____

Are there any medical issues, surgeries, or illnesses that have had a significant impact on you? (Circle one) Yes / No

If yes, please describe: _____

Are you currently taking any medication for a medical problem? (Circle one) Yes / No

If yes, please list medications below: _____

_____

_____

CURRENT AND PAST CONCERNS

Please circle the issues you are currently seeking help for: (Circle each one)

ANXIETY SUICIDALITY ANGER DECISION MAKING DEPRESSION
ASSERTIVENESS AGGRESSION / VIOLENCE FEARS LONELINESS
LOW ENERGY HOPELESSNESS PHYSICAL COMPLAINTS SEXUAL ISSUES
PROBLEM SOLVING JOB/CAREER ISSUES SHYNESS SOCIAL SKILLS
RELATIONSHIP / MARITAL ISSUES MOOD SWINGS BODY IMAGE INSOMNIA
IRRITABILITY REGRETS IMPULSIVITY SELF-CRITICISM SELF-ESTEEM
OBSESSIVE THOUGHTS PROCRASTINATION CONFLICT RESOLUTION
ALCOHOL / SUBSTANCE ABUSE PANIC MEETING PEOPLE

OTHER (please specify): _____

_____

Are there any sources of stress you have experienced in the past year? (Circle one)
Yes / No

If yes, describe: _____

Have you ever experienced a trauma? (Circle one) Yes / No

If yes, describe: _____

Where were you on September 11, 2001? _____

Are there any situations or people you avoid because they make you feel anxious?
(Circle one) Yes / No

If yes, describe: _____

Do you exercise? (Circle one) Yes / No

If yes, is your exercise excessive?_____

What are some things you like to do for fun (e.g. sports, hobbies, leisure)? _____

_____

_____

Describe your eating habits: _____

Have you ever had an eating disorder (e.g., Anorexia, Bulimia, or Binge Eating)?
(Circle one) Yes / No

If yes, which disorder and when? _____

How much coffee, tea, or caffeine do you consume daily? _____

Have you ever had or do you have a problem with substance abuse? Yes / No

If yes, please list if alcohol, medication, illicit drugs and when: _____

_____

Have you ever experienced any of the following? (Circle each one)

CONSUMING MORE THAN FIVE DRINKS IN ONE DAY

FEELING AN OVERWHELMING NEED TO DRINK

DRIVING WHILE INTOXICATED

NOT ABLE TO RECALL EVENTS THE NIGHT AFTER YOU DRINK

PEOPLE CLOSE TO YOU THINKING YOU HAVE A DRINKING PROBLEM

DRINKING TO REDUCE YOUR ANXIETY

Have you ever had a period of two days or more when you experienced any of the following? (Circle each one)

DECREASED NEED FOR SLEEP - VERY TALKATIVE - RACING THOUGHTS EASILY

DISTRACTED - UNUSUALLY HIGH SELF ESTEEM - DRIVING VERY FAST UNUSUAL

DESIRE TO SPEND MONEY - VERY IRRITABLE OR ANGRY

Is there anything else you would like me to know about you? (Please attach separate piece of paper if needed) _____

SYMPTOM EXPERINCE

Please describe your presenting symptom(s) **in depth** including:

(a) Symptom(s) FIRST appearance:_____

(b) WORST experience of the symptom(s) _____

_____

(c) Last time you experienced the symptom(s)_____

(d) Frequency of the symptom(s) _____

(e) What was taking place in your life when the symptom(s) FIRST presented_____

_____

_____

(f) Your theory on the cause of the symptom)s) _____

_____

_____

FAMILY AND RELATIONSHIP HISTORY

Family of Origin

Are your biological parents (Circle one):

Co-habitating / Married / Separated / Divorced / Never Married?

If your parents are separated or divorced, please indicate: _____

How old you were at the time of the separation/divorce? _____

If you were a minor at the time of separation/divorce, which parent you did you primarily reside with?_____

Did you maintain contact with your non-custodial parent? Please describe:_____

What does your family of origin look like at its best?_____

What does your family of origin look like at its worst? _____

How did people express anger or settle conflicts in your family? _____

_____

What was your role in your family of origin (i.e., caretaker, mediator, black sheep, rebel)?
_____

Part II

(A) Please describe your relationship with your parents as a child. Start as far back as you can remember:

_____

_____

_____

_____

(B) In what ways do you believe your relationship with your parents, when you were a child, has effected your adult personality, please describe:

_____

_____

_____

_____

(C) Were there many changes in your relationship with your parents after childhood, please describe:

_____

_____

_____

_____

What is your relationship with your parents NOW, please describe:

_____

_____

_____

_____

Relationship History

Are you satisfied with the quality, frequency and/or quantity of your dating and romantic relationships? (Circle one) Yes / No

If no, please describe: _____

_____

If you are currently in a relationship, how satisfied are you with the relationship? (Please circle one)

EXTREMELY UNHAPPY - FAIRLY UNHAPPY - A LITTLE UNHAPPY - HAPPY

VERY HAPPY - EXTREMELY HAPPY - PERFECT

What do you enjoy most about your boyfriend/girlfriend/partner/spouse? _____

_____

What do you and your boyfriend/girlfriend/partner/spouse disagree on most frequently / intensely? _____

Have you ever been the victim of domestic violence? (Circle one) Yes / No

If yes, please describe and indicate if the abuse is on-going: _____

If you identify yourself as gay/lesbian/bisexual, have you come out to your family? (Circle one) Yes / No

If yes, how old were you when you came out? _____

How did your family respond to your coming out? _____

Family Psychiatric History

For the individuals listed below, please provide the following information:

- Living / Deceased (If deceased, please note year and cause of death)

- Age

- Occupation (Please list past and present)

- Mental health issues/ Psychiatric diagnoses/ Alcohol or substance abuse

Mother _____

_____

_____

Father _____

_____
_____

Sibling _____

_____
_____

Sibling _____

_____
_____

Sibling _____

_____
_____

Step-Mother _____

_____
_____

Step-Father _____

_____
_____

Half-/Step- Sibling _____

_____
_____

Half-/Step- Sibling _____

_____
_____

Any psychiatric history among your grandparents, aunts, or uncles? Please describe and note if maternal or paternal:

_____ _____

_____

_____
_____
_____