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|  | **Dr. Eva Adriana Wilson, MD, FRCPC****Psychiatrist, Assistant Professor**998 Parkland Drive, Unit 206Halifax, NS B3M 0A6 | Phone: (902) 407-6600Fax: (902) 407-6601info@inspiredlivingmedical.com |

**Welcome to Inspired Living Medical,**

**In order for you to get the most out of our meeting, we require that you complete and return this form to our office no later than 2 WEEKS PRIOR** **to your scheduled appointment.** The completed forms can be sent to us via e-mail attachment, by fax, dropped off in person or sent by mail. If you opt to send it by e-mail, you do so with the understanding that it is not possible to completely guarantee the security and confidentiality of electronic correspondence. **If we do not receive these forms at least 2 weeks in advance of your scheduled appointment, we will have to cancel and reschedule as we require sufficient time to prepare for the assessment. *If you experience difficulties completing this form, please contact our office as soon as possible and we can discuss a reasonable extension for submission of the form.***

I will review some of this information in more detail during the assessment, in order to better understand the struggles you face. Some of the items may not seem relevant to your presentation, however, many conditions overlap, so it is important to complete the entire form. This will allow me to most accurately determine what is going on and what resources would be most helpful to you moving forward. ***Although the form appears to be lengthy, much of it requires few words or yes/no answers, so it should not take too long to complete.***

**Payment, cancellations and late arrivals policy:**

Your assessment is covered by your provincial health plan (MSI) **as long as your MSI card is valid. *Please check your expiration date prior to your appointment*** and present your health card to our staff upon arrival of your assessment to avoid incurring any charges.

A fee of **$200 +HST is charged if we are given less than 48 hours of notice for cancellation** of your appointment and late arrivals are subject to a fee of **$50/ per 15 minutes of tardiness.**

**What to expect from the assessment:**

The appointment will last approximately 1.5 hours. I will review any diagnoses and recommendations

for therapy, medication, or other interventions with you at the end. A copy of the report will be sent

to the referring physician who can follow up on any recommendations made. I no longer offer individual

therapy, however, I do offer a particular form of group therapy when clinically indicated. This will be

discussed with you if it applies in your circumstances. I do provide detailed recommendations for

resources and suitable therapists available in the community as part of the report, so you should leave

with a clear plan about your next steps.

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| **NAME:** |  | **DATE COMPLETED:** | **DOB** (YYYY/MM/DD): |  |
| **Health Card #** |  | **Exp. Date:** |  |

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| Please answer the following based on how you have been feeling **in the past 2-3 weeks** (unless otherwise directed) |
| **Rate your MOOD(independent of anxiety)** Based on most days, from 1-10. 1 = so sad you can’t get out of bed.10 = the happy go lucky we see on TV. | **Rate your mood at BASELINE**, what is has been for most of your adult life when things are ok and there is no particular crisis.  **/10***Comments:* |
| **Rate your mood at in the past 2-3 weeks: /10***Comments:* |
| **If different than your baseline, WHEN did you first notice it starting to drop & why do you think that happened?**  |
| **SLEEP** | **How long does it usually take you to FALL ASLEEP?** |
| **How many times do you WAKE UP/ night? For how long**? |
| **How often do you wake up in the EARLY MORNING (before 6 am) and stay up all day because you can’t get back to sleep?** |
| **INTERESTS** | **What do you usually ENJOY doing?** |
| **Have you been able to enjoy these things as usual lately?**  |
| **GUILT &** **NEGATIVE THINKING** | **Do you find yourself getting stuck in feelings of** **GUILT or NEGATIVE THINKING?** |
| **How do these compare lately relative to what is normal for you?** (better, worse, at baseline) |
| **If there has been a change, what do you think helped or made it worse?** |
| **ENERGY**  | **How are your energy levels from 1-10? (1= low, 10= good): /10***Comments:* |
| **How are your energy levels at baseline compared to other people your age?** **/10** *Comments:* |
| **Please check “✓” or “X” which best describes your current patterns for each of the following when compared to your baseline (what is typical for you when you feel like yourself):**

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|  | **Baseline** | **Worse** | **Better** | **How Often** |
| **Hygiene** |  |  |  |  |
| **Cooking** |  |  |  |  |
| **Basic Housekeeping** |  |  |  |  |
| **Working** |  |  |  |  |
| **Grocery shopping** |  |  |  |  |
| **Paying bills** |  |  |  |  |
| **Managing meds** |  |  |  |  |
| **Driving** |  |  |  |  |
| **Leaving the house** |  |  |  |  |

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| **CONCENTRATION** | **How is your concentration in recent weeks?** |
| **How is it normally?**  |
| **Has this been an issue for you in the past? Please be specific.** |
| **APPETITE** | **How is your appetite lately?** |
| **Have you had any recent weight changes?**  |
| **Has this been an issue for you in the past? Please be specific.** |
| **PAST HISTORY OF DEPRESSION**Have you ever had your mood drop and **STAY** low for weeks at a time **AND** have changes in your sleep, concentration, energy, appetite?  | **Please specify approximate dates/ years:** |
| **Did you miss school or work at that time because of how you were feeling? How often or how much?** |
| **How did you get out of previous periods of low mood?** |
| **Were you ever hospitalized in a Psychiatric facility? If so, when?** |
| **LONGSTANDING ISSUES** | **Please underline (or circle) which if any of the following have been a longstanding struggle for you:****Low mood, sleep, appetite, energy, concentration, indecision, feelings of hopelessness, self esteem** |

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| **RISK ASSESSMENT** |
| **SUICIDAL THOUGHTS** | **Have you EVER had thoughts of being better off dead or wishing something would happen that would cause your death?**  |
| **Have you EVER had thoughts of doing something to kill yourself?** **If so, what was your PLAN?** |
| **Have you EVER had a suicide attempt before? If so when?**  |
| **Have you been having suicidal thoughts in the past few weeks? How often?** |
| **SELF HARM**  | **Have you EVER engaged in SELF HARM (cutting, burning etc.)?**  |
| **What form? How often?** |
| **HOMOCIAL THOUGHTS** | **Have you EVER had thoughts of killing another person, and actually planning their murder?**  |
| **LEGAL HISTORY**  | **What charges have been brought against you?** (Please provide approximate dates where possible) |
| **Have you ever been in jail? If so, for how long?** |
| **Are there current legal charges against you or pending? Are you on probation?** |

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| **Have you had periods where your MOOD was abnormally HIGH, or irritable** **✓ AND you didn’t need to sleep more than 2-3h/ night for days or more at a time** **✓ AND didn’t feel tired****✓ AND it was getting you into trouble?** | **When did this happen? How often does it happen?**  |
| **What kinds of comments were people making to you at that time?** |
| **How were you acting differently? (Please be specific)** |

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| **Have you ever wondered if you were seeing or hearing things that other people didn’t hear or see?**  | **Please provide details.** |
| **HABITS/ ROUTINES**  | **Please underline (or circle) any of following that apply to you.** **I get stuck in, or get preoccupied (for more than 1h/day) with routines involving…****Concerns about contamination, cleaning/ washing, ordering/ arranging, hoarding items without sentimental value, repeating rituals, checking rituals, reassurance seeking, counting rituals, excessive list making, aggressive or sexual intrusive thoughts.** |
| **ANXIETY**  | **Do you find you worry more than is appropriate for your circumstance AND worrying interferes with your life?**  |
| **What kinds of things do you worry about? (Please be specific)** |
| **Please specify which of the following goes along with your worry:** |
| * **Feeling tense**
* **Difficulty concentrating**
* **Mind going blank**
* **Feeling irritable**
 | * **Sleep Issues**
* **Tired/ fatigue**
* **Feeling restless**
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| **How often do you drink coffee, tea, pop or energy drinks?** **How often do you eat chocolate?** |
| **SOCIAL BEHAVIORS** | **Do you have any trouble with meeting new people?** |
| **If so, are you afraid you will EMBARASS yourself or be RIDICULED?** |
| **Do you AVOID socializing as a result of this? Does this cause any problems for you at home, with friends, school, or work? (Please be specific)** |
| **PANIC** | **Please circle any of the following that apply to you:**Sudden onset of severe anxiety **in a situation that was unexpected** and was associated with a feeling of impending doom, chest tightness, shortness of breath, stomach upset, numbness or tingling, sweating.**Came on very quickly, left in 20-30 min** |
| **How often does this happen?**  |
| **Did you change your behavior or avoid places because of fear this would happen again (**i.e. Panic attack while driving, so stopped driving)? |
| **HISTORY OF TRAUMA** | **Please list any instances of times you felt your life was threatened or you witnessed someone else’s life be threatened, or that you experienced sexual abuse or assault. (Please include approximate dates or ages at time of trauma)** |
| **Do you have INTRUSIVE memories or thoughts related to these events? Which one(s):** |
| **Do you AVOID thinking or talking about them? Do you avoid people, or places related to the trauma?** |
| **How do you think these events continue to impact your life? If at all.** |

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| **SUBSTANCE USE HISTORY** | I started to use **ALCOHOL** at age:At my peak I was drinking (indicate AMOUNT and FREQUENCY):It became an issue for me (indicate when, if at all):In the past few months I have been drinking (indicate AMOUNT and FREQUENCY):Have you ever sought treatment in the past from Addiction Services, AA or a Detox facility? (Yes or No). If yes, please indicate for what substance, when and where.My longest period of sobriety has been? Indicate dates please. |
| **How often do you use pot recently? (cannabis, or hash)** |
| **At your peak of use?**  |
| **Please list any other street drugs, IV drugs you have used (ever).****Please list any over-the-counter medication or prescription medications you have misused or abuse:****Do you use any tobacco products currently or in the past? If so, how much?** |

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| Please use an “ x “ to indicate which of the statements are true for the corresponding substances: |
| **Statement** | **Alcohol** | **Cannabis**(Pot or Hash) | **Cocaine** | **Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Please specify) |
| **Used in larger amounts than intended or over a longer period than intended.** |  |  |  |  |
| **Desire or unsuccessful efforts to cut down or control its use** |  |  |  |  |
| **A lot of time spent in activities to get it, use it or recover from it.**  |  |  |  |  |
| **Cravings and strong urges to use the substance in question** |  |  |  |  |
| **Recurrent use impacting obligations at home, work or school.** |  |  |  |  |
| **Continued use despite it causing or worsening relationship issues with family, friends or co-workers** |  |  |  |  |
| **Important social, occupational, or recreational activities being given up or reduced because of it.** |  |  |  |  |
| **Use in situations where it is dangerous** *(i.e.. Driving, working etc.).* |  |  |  |  |
| **Physical or mental condition worsened by its use.** |  |  |  |  |
| **Tolerance** *(need more to feel the effect or less effect with same amount).* |  |  |  |  |
| **Withdrawal** *(Or use to avoid withdrawal).* |  |  |  |  |

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| **ATTENTION SCREEN**  | **Please underline (or circle) which of the following apply to you:****History of inattention dating back to elementary school, making careless mistakes, difficulty staying focused, seemingly not listening when spoken to, difficulty following through on instructions or completing work in allotted time, difficulty staying organized, poor time management, avoiding tasks that required sustained attention (procrastination), often losing things, easily distracted, often forgetting things (i.e. Appointments, pay bills etc.).**  |
| **Please underline (or circle) which of the following apply to you, in addition to the above:****History of being fidgety, needing to leave my seat and walk around, running about or climbing as a child in inappropriate situations, talking excessively, blurting out answers as a child and having difficulty waiting my turn.** |
| **These behaviors were present before age 12 yo?** |
| **They happened in at least 2 different situations (i.e. Home and school)** |
| **PERSONALITY FEATURES** | **Please underline (or circle) which of the following apply to you:****Sensitivity to abandonment or rejection, feelings of emptiness, lots of drama in my interpersonal relationships, issues with mood being really up and down even within the course of a single day, issues with anger, losing myself when in relationships with others (taking in their interests and dropping my own),** **impulsivity (making rash decisions),** **longstanding and chronic suicidal thoughts,** **longstanding history of self-harm****Need to inflate my sense of self-importance, often at other people’s expense****Struggle to make decisions on my own, need to people please even when it is bad for me.****History of illegal activity (dating back to age 15 or younger)****Reckless disregard for my own or other people’s safety****Difficulty holding a job or honoring my commitments****Frequent deceitfulness, conning others or pervasive lying to serve my needs****Repeated physical fights or assaults** |
| Any additional comments or information your loved ones wish to share |  |

**CURRENT MEDICATIONS**

*Please answer the following to the best of your ability, put a “?” if you are not sure and you can see a list below of common medications used in psychiatry if you need a reminder to jog your memory.*

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| MEDICATION | DOSE | HOW LONG at this dose? | RESPONSE | SIDE EFFECTS |
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| **ALLERGIES** *(Please include what happens, so what your reaction is. E.g. Rash, nausea, anaphylaxis etc.):*  |
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 **PAST MEDICTION TRIALS**:   *Leave blank if you don’t recall or it doesn’t apply*

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| **MEDICATION** | **DURATION** | **MAX DOSE** | **RESPONSE** | **SIDE EFFECTS** |
| Cipralex/ Escitalopram |  |  |  |  |
| Celexa/ Citalopram |  |  |  |  |
| Prozac/ Fluvoxamine |  |  |  |  |
| Zoloft/ Sertraline |  |  |  |  |
| Luvox/ Fluvxamine |  |  |  |  |
| Paxil/ Paroxetine |  |  |  |  |
| Effexor/ Venlafaxine |  |  |  |  |
| Pristiq/ Desvenlafaxine |  |  |  |  |
| Cymbalta/ Duloxetine |  |  |  |  |
| Brintellix/ Vortioxetine |  |  |  |  |
| Wellbutrin/ Bupropion |  |  |  |  |
| **MEDICATION** | **DURATION** | **MAX DOSE** | **RESPONSE** | **SIDE EFFECTS** |
| Desyrel/ Trazodone |  |  |  |  |
| Norpramin/ Desipramine |  |  |  |  |
| Aventyl/ Nortriptaline |  |  |  |  |
| Elavil/ Amitriptaline |  |  |  |  |
| Anafranil/ Clomipramine |  |  |  |  |
| Tofranil/ Imipramine |  |  |  |  |
| Zopiclone/ Imovane |  |  |  |  |
| Seroquel |  |  |  |  |
| Abilify/ Aripiprazole |  |  |  |  |
| Ritalin (or Riatlin SR) |  |  |  |  |
| Biphentin |  |  |  |  |
| Concerta |  |  |  |  |
| Dexedrine (or Dexedrine spansules) |  |  |  |  |
| Addrerall XR |  |  |  |  |
| Vyvanse |  |  |  |  |
| Strattera/ Atomoxetine |  |  |  |  |
| Zyprexa/ Olanzapine |  |  |  |  |
| Risperdal/ Risperidone |  |  |  |  |
| Zeldox/ Ziprazidone |  |  |  |  |
| Latuda/ Lurasidone |  |  |  |  |
| Sapharis/  Asenapine |  |  |  |  |
| Lamictal/ Lamotrigine |  |  |  |  |
| Lithium |  |  |  |  |
| Valproic Acid |  |  |  |  |
| Epival/ Divalproate |  |  |  |  |
| **OTHER- Please specify:** |  |  |  |  |
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| **DEVELOPMENTAL HISTORY** *(If you answer yes to any of the below, please provide details)* |
| Were there any issues in pregnancy with you as far as you know? |  |
| Were there any complications at birth? |  |
| Were there any issues like illness or health problems in the first few months after birth? |  |
| Were there any concerns about your development, like when you talked, walked, your coordination or social skills?   |  |
| Were there any difficulties with learning (i.e. Math difficulties, repeating a grade etc.)? |  |
| Were there any social difficulties growing up? |  |

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| **PAST MEDICAL HISTORY**  |
| **Is there anything you need to see your doctor about other than routine check-ups?** |
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| **Do you have a history of, or currently struggle with any of the following?** *(Indicate Y or N)* |
| Anemia (low iron) |  |
| Vitamin B12 deficiency |  |
| Low testosterone |  |
| Sleep Apnea |  |
| Seizures |  |
| Head injuries with loss of consciousness |  |
| Thyroid problems |  |
| Diabetes |  |
| **Please list any surgeries you have had in the past**: *(Wisdom teeth, Appendicitis, Gallbladder removal, C-sections, Hysterectomy, etc.)* |
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| **FAMILY MEDICAL HISTORY:**  **Any particular illnesses that run in your family**? (i.e. Diabetes, heart disease or sudden death at an early age, cancer, etc.). Any heart issues leading to sudden death at young ages in your family? |
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**PAST THERAPY TRIALS:**

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| **PAST THERAPIST** (include names if you know them) | **How long or how many sessions?** | **Type of Therapy** | **Helpful or Not** |
| Psychologist |  |  |  |
| Other Therapist |  |  |  |
| Marital or Family Therapy |  |  |  |
| Psychiatrist |  |  |  |
| OTHER – Please Specify:*(i.e. Day Treatment Program at hospital or elsewhere, Cognitive Behavior Therapy, Dialectical Behavior Therapy, EMDR, Addiction Rehabilitation Facilities or contact etc.)* |  |  |  |
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| **Are you seeing anyone now?** *If so, please indicate their name and contact information below if you wish them to receive a copy of this report. Also, please say how often you see them.* |  |

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| **FAMILY PSYCHIATRIC HISTORY -** *Is there a history of any of the following in your family (blood relatives only)?* |
| Please indicate ***how they are related to you*** and if it is on your **mother (M) or father’s (F) side** (Y or N?): |
| Addiction *(Including: alcohol, drugs, gambling, pornography, other)* |  | Panic Attacks |  |
| Depression |  | Psychosis |  |
| Bipolar |  | Schizophrenia |  |
| Anxiety (General) |  | Autism |  |
| Obsessive Compulsive Disorder |  | ADHD |  |
| Post Traumatic Stress Disorder |  | Dementia (if before age 65 yo) |  |
| Social Anxiety |  | OTHER: | Incl. family history of suicide completion |  |

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| **PERSONAL HISTORY** |
| Where were you born and raised? Who raised you? |  |
| Who lived in your home with you? |  |
| What did your caregivers do for work? |  |
| How many siblings did you have, if any? |  |
| How would you describe your childhood? |  |
| What is your relationship like with your siblings? (If applicable) |  |
| What is/ was your relationship like with your parents? |  |
| What was your experience of conflict resolution and anger in childhood? |  |
| What was your experience of affection in childhood? |  |
| What is your highest level of Education? |  |
| Has learning been an issue for you? |  |
| Has bullying been an issue for you?*If yes, Physical? Verbal? Sexual? At home? At school? At work?* |  |
| List or describe your work history. |  |
| How long have you had your longest job? |  |
| List or describe your relationship history. |  |
| How long have you had your longest relationship? |  |
| What do you feel you are good at? **What are your strengths**? |  |
| What gives you a sense of **purpose** in life (reason to get out of bed in the morning)? |  |
| What gives you a sense of **meaning**, that you are contributing to something beyond yourself?  |  |
| What gives you a sense of **challenge and/ or creativity**? |  |
| **What is especially important to you at this stage of your life**? |  |

*Thank you for taking the time to complete this form as accurately as possible.*

*I look forward to meeting with you to discuss things further and see how I may be of help to you.*

*I suggest you check out our website for Resources while you wait for your appointment, www.InspiredLivingMedical.com. It includes a “****Therapists in Halifax****” page for those seeking to start treatment while they wait. Should your symptoms worsen, please contact your GP, present to the nearest Emergency room or contact the* ***Mobile Crisis Team at 902-429-8167*** *for assessment.*

*Warmest wishes,*

*Dr. E. Adriana Wilson*

*B.Sc, B.A., MD, M.Ed., FRCPC*

*Assistant Professor, Faculty of Medicine,*

*Dalhousie University Department of Psychiatry*