

PATIENT CONTACT INFORMATION

PATIENT:					
DOB:	dd/mmm/yyyy	Personal Health Number	_____ - _____	Gender:	<input type="checkbox"/> M <input type="checkbox"/> F
Address:				Phone:	
City:		Province:		Postal Code:	

LEGAL GUARDIAN:					
<input type="checkbox"/> Court Appointed <input type="checkbox"/> Parent (Patient under 18 years old)					
Name				Relationship to Patient:	
Phone:			Alt Phone:		
Address:					

RESIDENTIAL CONTACT:			VOCATIONAL CONTACT:		
Name				Name:	
Phone:				Phone:	
Agency:				Agency:	
Address:			Address:		

PDD CLIENT SERVICES COORDINATOR:		Phone:	
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PREFERRED CONTACT PERSON:					
Name				Relationship to Patient:	
Phone:	Home:	Work:	Cell:		
Address:					

FAMILY DOCTOR:			
Name			
Phone:			Fax:
Address:			

OTHER DOCTOR'S NAME:	SPECIALTY	PHONE	FAX

PHARMACY:			
Name			
Phone:			Fax:
Address:			

ALLERGIES:	
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ARNIKA INTAKE QUESTIONNAIRE

Name: _____

DOB: (dd/mm/yyyy) dd/mm/yyyy Sex: Male Female

Form Completed By: _____

Position: _____

Date Completed: dd/mm/yyyy

Other Support Services (e.g. psychologists) other than contacts listed on *Patient Contact Information*.

Name	Agency	Phone #	Service Provided

A. CURRENT CONCERNS/CHIEF COMPLAINT

Briefly state why this person is being referred for psychiatric evaluation. What assistance are you seeking regarding these concerns?

Duration of current problems:

1 - 3 months 3 - 6 months 6 - 12 months 12 + months

ARNIKA INTAKE QUESTIONNAIRE

B. FAMILY HISTORY OF MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, NEUROLOGICAL ILLNESS OR SEIZURES

List biological relatives who have a history of mental illness, mental handicap developmental disability, neurological illness or Seizures. This includes suicide attempts, severe substance abuse, psychiatric hospitalization and or treatment.

No information available

Relationship to Client	Illness	Treatment Date

C. PREGNANCY AND DELIVERY

No information available

Duration of Pregnancy (in months) _____

During pregnancy was alcohol, drugs or medications used?

Don't know No Yes - describe

Birth weight (if known) _____ lbs _____ oz

Apgar Score (if known) 1 minute 5 minutes

Delivery Spontaneous Induced Caesarean

Complications for pregnancy or delivery No Yes - describe

D. EARLY DEVELOPMENT

1. Milestones: No information available

Sat Up	Walked	1 st word	Talked (Phrase)	Trained Urine	Trained Feces

2. Any unusual speech problems: Describe

ARNIKA INTAKE QUESTIONNAIRE

3. Mental Handicap Diagnosis: No information available
 Age when diagnosis first made: _____
 Cause of mental handicap (if known): _____
4. Has genetic testing been done? No Yes - Date _____
 Results: _____

E. DEVELOPMENTAL DISABILITIES INFORMATION (Please enclose a copy of any testing, if available)

1. IQ Testing: Full Scale Score: _____
 No information available

2. Other testing (Adaptive, speech language, physiotherapy, Occupational therapy, etc.) No information available

Test Administered	Date	Examiner	Results

3. Has the client been diagnosed as suffering from an Autism Spectrum disorder?
 No Yes - if available please enclose report.

F. EDUCATIONAL HISTORY

List schools attended: No information available

Name	Grades Attended	Comments

G. RESIDENTIAL/INSTITUTIONAL PLACEMENTS

List previous residential placements

Agency	Admission Date	Discharge Date	Comments

Respite Care No Yes Frequency _____

ARNIKA INTAKE QUESTIONNAIRE

H. VOCATIONAL PLACEMENTS

List previous vocational placements or day programs

Agency	Admission Date	Discharge Date	Comments:

I. MEDICAL HISTORY

Medical History	No	Yes	Describe
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal EEG	<input type="checkbox"/>	<input type="checkbox"/>	
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	
MRI	<input type="checkbox"/>	<input type="checkbox"/>	
Tics or Tremors	<input type="checkbox"/>	<input type="checkbox"/>	
Any other type or neurological troubles e.g., headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Specific communication disorder (e.g., inability to talk)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory problem (eg. Asthma)	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach or intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	
Gynecological problems	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic problems	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	
Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	

J. PAST HOSPITALIZATIONS (Psychiatric / Medical / Surgery):

Date	Name of Hospital	Describe Surgery or Reason for Hospitalization

ARNIKA INTAKE QUESTIONNAIRE

K. CURRENT PHYSICAL AND MENTAL FUNCTION

Consider the previous 3 months in completing this inventory

Physical Function	Concerns
Sleep	
Appetite	
Mood	
Thoughts (Unusual)	
Aggression	
Energy Level	
Concentration Ability	
Bowel and Bladder Concerns	
Menstrual Concerns	
Sexuality	

L. CURRENT MEDICATIONS:

Medications	Dose	Times/ Day	Effect	Prescribing Physician	Date Started

M. PREVIOUS TRIALS OF MEDICATIONS:

Medications	Dose	Start Date	End Date	Describe Result