Dr. William Winogron
Psychological Therapy • Intake Form

Please provide the following information and answer the questions below. Information you provide here is protected as *confidential* information.

General Identification & Information

Name: _____

(last name/ first name/ middle initial)

Birth Date: (d) _____ / (m) _____ / (yr.) _____ Age: _____

Gender: ☐ Male ☐ Female

Address:

_____

(street/ number)

_____

(city/ province/ postal code)

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/their ages: _____

_____

Home Phone: (_____) _____) May we leave a message? ☐Yes ☐ No

Cell/Other Phone: (_____) _____) May we leave a message? ☐Yes ☐ No

E-mail: _____ May we email* you? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by: _____

Reason for this referral to a psychologist: _____

_____

Dr. William Winogron, Psychologist
Dr. C. Gow & Associates, 265 Carling Ave., Suite 200, Ottawa, ON, K1S 2E1
Ph.: 613-565-0087; Fax: 613-565-5621

Have you previously received any type of **mental health services** (psychotherapy, psychiatric services, etc.)?

☐ No; ☐ Yes; if yes, name of previous therapist/practitioner:

_____

Have you ever been prescribed **psychiatric medication**?

☐No; ☐Yes; If yes, please list and provide dates: _____

_____

_____

Emergency Contact

Please provide the name and contact information for someone we can contact in the event of an emergency

Name/address/relationship to you:

_____

_____

Home Phone: (_____) _____) May we leave a message? ☐Yes ☐ No

Cell/Other Phone: (_____) _____) May we leave a message? ☐Yes ☐ No

Your Health

How would you rate your current **physical health**? (please circle)

Poor *Unsatisfactory* *Satisfactory* *Good* *Very good*

Please list any specific health problems you are currently experiencing:

_____

Sleep

How would you rate your current **sleeping habits**? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

Exercise

How many times per week do you generally **exercise**? _____. What types of exercise to you participate in?

_____

Eating

Please list any difficulties you experience with your **appetite or eating patterns**.

_____

_____

Emotions

Are you currently experiencing overwhelming **sadness, grief or depression**?

☐ No; ☐ Yes; If yes, for approximately how long? _____

Are you currently experiencing **anxiety, panic attacks or any phobias**?

☐ No; ☐ Yes; If yes, for approximately how long? _____

Are you currently experiencing any chronic **pain**?

☐ No; ☐ Yes; If yes, please describe _____

Substances

Do you drink alcohol more than once a week? ☐ No ☐ Yes

How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Relationships

Are you currently in a romantic relationship? ☐ No ☐ Yes; If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Life events

What significant **life changes** or **stressful events** have you experienced recently?

_____

_____

Family mental health history

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's **biological relationship** to you in the space provided (father, grandmother, uncle, etc.).

Please Circle (yes or no) & List Family Member

Alcohol or Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional information

Are you currently employed? ☐ No ☐ Yes; If yes, what is your current employment situation?

_____

Do you enjoy **your work**? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be **spiritual or religious**? ☐ No ☐ Yes

If yes, describe your faith or belief:

_____

_____

What do you consider to be some of your **strengths**?

_____

_____

_____

_____

What do you consider to be some of your **weakness**?

_____

_____

_____

_____

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What would you **like to accomplish** out of your time in therapy?

_____

_____

_____

_____

End of form • Please review the form to find and complete any items you may have skipped

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