



INSPIRED LIVING MEDICAL
— LIVE YOUR EPIC LIFE —

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ELECTRONIC CORRESPONDENCE AGREEMENT

I (patient) understand and accept the risks associated with the use of electronic correspondence of my medical records and reports with our clinicians and staff at Inspired Living Medical Inc .

Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to guarantee the security and confidentiality of electronic communications.

I acknowledge and understand that it is possible that communications with clinicians and staff using the services may not be encrypted.

I acknowledge that I fully understand the risks, limitations, and conditions for use of electronic communication correspondence pertaining to this consent form.

I agree to communicate with our clinicians and staff by electronic methods with a full understanding of the risks involved.

I acknowledge that either I or the physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Patient Name: _____ **DOB (MM/DD/YYYY):** _____

Signature of Acknowledgement: _____

Date: _____

Witness Name (printed): _____

Witness Signature: _____



Dr. Eva Adriana Wilson, MD, FRCPC
 Psychiatrist, Assistant Professor

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Welcome to Inspired Living Medical,

Filling out the intake form:

- Please complete to the best of your ability and **return at your earliest convenience**. Most questions are check boxes and long answers are not necessary. You will have a chance to elaborate during your consultation appointment.
- Once you have completed your intake form, you may email it as an attachment to info@inspiredlivingmedical.com, or mail it in at the mailing address above.
- Once received, we will reach out to you with an appointment time. Appointments are booked as intake forms are returned, therefore the earlier you return your intake form, the earlier you will be scheduled for an appointment.
- If we do not receive your completed intake form within 3 months of the mailing date, we will assume you are no longer interested in this appointment and return the referral back to your referring clinician. Please reach out if you require more time to fill out the intake form and we can make exception to this.

What to expect from the assessment:

- Our one-time consultation typically last 1.5-2hrs. 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 clinician who can follow up on any recommendations made. Implementation and individual follow up happens with your GP or NP, in combination with the resources that are recommended.
- Consultations are offered in-person or virtually (Zoom video call or telephone), please indicate below your preference.
- YOU **MUST BE PHYSICALLY IN Nova Scotia** even if you have a virtual appointment.
- If you have any questions about what to expect, please reach out to admin via phone or email.
- *Should your symptoms worsen, please contact your GP or NP, present to the nearest Emergency room or contact the **Mobile Crisis Team at 902-429-8167** for assessment.*

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*. You may be asked to present your health card and expiry upon arrival or as part of verifying your identity for virtual appointments, so please have your card with you.
- A fee of **\$240 + HST is charged when less than 2 business days of notice is provided for a cancellation** of your appointment and late arrivals are subject to a fee of **\$60 + HST per 15 minutes of tardiness**.
- Our automated appointment reminder system will send you a message 3-4 business days prior to your scheduled appointment to help avoid late cancellation fees, please indicate below how you would like to receive this reminder.

| | | |
|--|--|--------------------------|
| Your NAME: | DATE COMPLETED: | DOB (YYYY/MM/DD): |
| Preferred Pronouns: <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them | | |
| Health Card #: | Health Card Expiry Date: | |
| Family Doctor's name: | Phone number and Clinic Location (Family Doctor's): | |
| Your Preferred Appointment type: <input type="checkbox"/> In-Person <input type="checkbox"/> Zoom Video Call* <input type="checkbox"/> Telephone Call* *If virtual, please review the virtual consent video on our website (www.InspiredLivingMedical.com/Intake): <input type="checkbox"/> I have watched the video and consent to virtual care | Appointment Reminder will be sent via (please choose only one): <input type="checkbox"/> Email <input type="checkbox"/> Text message <input type="checkbox"/> Automated phone call Confirm email/phone #: Add me to cancellation list: Yes No | |

In order to best help you, please complete the sentences below:

1. I want help with:
2. So far I have tried:
3. I am hoping you can help me by:

PERSONAL HISTORY

- I was born in *(where)* _____ and raised by: *(who)* _____.
- I lived most of my life in:
- My parents are: Together Separated/Divorced Deceased
- My caregivers supported us by *(what did they do for work/income)*:
- I would describe my childhood as:

- I had/ have (#) _____ siblings. My relationship with my siblings is (if applicable):
- My relationship with my parents is/ was:
- In my home growing up, conflict was handled by: Talking things through / Yelling / Violence / Loss of privileges / Silent treatment / Pretending nothing happened (ignoring/avoiding)/ Other:
- In my home growing up, affection was shown by: Hugs / Kisses / I love you's / Words of affirmations / Gifts / Eating meals together / Spending time together / Emotional support / Other:
- My highest level of education is:
- My work history includes:
- My longest work position has been:
- My sexual orientation is:
- My relationship history includes:
- My longest relationship was:
- My current supports include *(people you can lean on)*:
- My strengths are:
- My sense of purpose comes from:
- My sense of meaning, like I am contributing to something beyond myself, comes from:
- My creative outlets include:
- My sense of challenge comes from:

Comments, Observations or Concerns from Your Loved Ones

(You may wish to include comments, observations, or concerns from your loved ones in this section of the intake form, or separately enclosed with this intake.)

Please answer the following questions based on the past 2-3 weeks unless otherwise specified.

My **MOOD** through most of my adult life has been ___/10 (1= so low can barely get out of bed; 10= happy go lucky)

- My mood in the past few weeks has been ___/10
- **When** and **why** do you think it changed?

SLEEP: I fall asleep Quickly (within 30 mins) / It takes 1 hour or more / It changes night to night.

I wake up ___ # of times per night and fall back to sleep in ___ minutes. I wake up before 6 am ___ # days/ week.

I have diagnosed sleep apnea: Yes No If yes, I use a CPAP regularly: Yes No

Things that I typically **ENJOY** doing: _____

I have been enjoying these as usual lately: Yes No

I have been prone to **GUILT & NEGATIVE THINKING** throughout my life: Yes No

Negative thinking has been Worse / Better / The same as usual in recent weeks.

The change is due to: _____

My **ENERGY** at baseline is Similar / Lower / Higher compared to other people my age, and recently my energy is

Worse / Better / The same as usual. I get **physical exercise**: ___ # of times/ week.

FUNCTION:

Currently the following areas are worse than my usual: Hygiene / Cooking / Basic housekeeping / Working /

Grocery shopping / Paying bills / Managing medications / Driving / Leaving the house.

CONCENTRATION at my baseline is ___/10 and recently it is ___/10 (1= very low, 10= great)

I have a history of A learning disorder ADD/ADHD diagnosis None.

My **APPETITE** has been Stable / Lower than usual / Higher than usual / Variable / Eating emotionally or out of

boredom and I my weight has: No change / Weight Gain / Weight loss / Intentional (if loss or gained)

My usual adult height is _____ and weight is: _____. I eat 5+ servings of fruit/vegetables daily: Yes No

COPING

I have Never / Occasionally / Often had thoughts I would be better off dead or plans to kill myself.

I Have/ Have not had PRIOR SUICIDE ATTEMPTS. If yes, how many and when? _____

I Have/ Have not engaged in SELF HARM (e.g. hitting, burning, cutting). If yes, how and when? _____

LEGAL HISTORY: I have No / Current / Past legal charges or time served. If yes, what were the charges and when? ↓

I Have/ Have not had a serious plan and intention to kill someone else currently or in the past.

I Have/ Have not had **PAST EPISODES** of depression. If so, when? _____

I Have/ Have not had a psychiatric **HOSPITALIZATION**.

AT BASELINE I chronically struggle with: Low mood (2+ yrs) / Sleep issues / Appetite issues / Low energy /

Difficulty with concentration Indecision / Feelings of hopelessness / Low self esteem / None of these.

MANIA

- I have had periods of 4 consecutive days or more when my mood was abnormally high or irritable AND I was only sleeping 2-3h/ night AND I did not feel tired AND I was acting in unusual ways that were commented on by others. (Specify details including when and how often):

- I have had times when I wondered if I was seeing or hearing things other people did not see or hear. Please provide details:

OCD

Please indicate if you feel you get stuck in, or preoccupied with, routines or thoughts involving (check all that apply, if any):

- Concerns about contamination, cleaning/ washing
- Ordering/ arranging
- Hoarding items without sentimental value (empty envelopes, old clothes)
- Repeating rituals (re-reading emails, re-writing things until it feels "just right")
- Checking rituals (doors, windows, stove, faucets, etc.)
- Reassurance seeking
- Counting rituals
- Excessive list making (stops being helpful)
- Aggressive or sexual intrusive thoughts

GENERAL ANXIETY

Do you feel that you **worry more than is appropriate** for your situation AND it interferes with your life? Yes No

If yes, **what do you tend to worry about:**

For you, is **worry is associated with:** Tension / Sleep difficulty / Fatigue / Concentration difficulties / Irritability / Mind going blank.

I drink **coffee, tea, pop or energy drinks** ____ times/ week or ____ times/ day. I eat **chocolate** ____ times/ week.

PANIC

Please check all that apply:

- I have had sudden onset of panic that came on suddenly and left in 20-30 min
- It happened ____ times or ____ times/ week
- I worry it will happen again

If yes, the panic was associated with: Feeling of impending doom / Chest tightness / Shortness of breath / Stomach upset / Numbness or tingling/ Sweating a lot / None of these.

SOCIAL ANXIETY

Please check all that apply:

- I feel **anxious** in **social situations**
- I worry about being **judged**, being **ridiculed**, or being **embarrassed**
- The social anxiety **interferes with my ability to function in my life** (please specify how):

HEALTH ANXIETY

Please check all that apply:

- I worry **more than most** about my **physical health**
- I am **easily alarmed** by **physical symptoms**
- This worry **interferes with my life**
- I tend to get **physical symptoms** when I am **stressed** (please indicate which, i.e., IBS, migraines, headaches requiring medicine or time off work):

TRAUMA

Please check all that apply to you:

- I have felt my life was threatened
- I witnessed someone else's life be threatened
- I experienced sexual abuse or assault

If positive for any of the above, please include approximate dates or ages at time of trauma:

Please check all that apply to you regarding this event(s):

- I have intrusive thoughts, memories or dreams related to these/ this event(s)
- I get physically distressed when I think or am reminded of them
- I avoid thinking or talking about them
- I avoid people, places or reminders of the event(s)
- I feel these events still impact my life (specify how):

SUBSTANCE USE

Please check the box for each substance you have ever used. For positive answers, please indicate your current amount of use and peak amount of use for how long (e.g. 1 bottle of wine/week for 6 months).

Alcohol

Current use: Peak of use:

Cannabis

Current use: Peak of use:

Tobacco

Current use: Peak of use:

Opioids (*Oxy, Dilaudid, Fentanyl, etc.*)

Current use: Peak of use:

Cocaine or stimulants (*Adderall, Ritalin, etc.*)

Current use: Peak of use:

Hallucinogens (*LSD, mushrooms, etc.*)

Current use: Peak of use:

Benzodiazepines (*Xanax, Ativan, Clonazepam, etc.*)

Current use: Peak of use:

Other prescription drugs *pls specify:*

Current use: Peak of use:

Other non-prescription drugs *pls specify:*

Current use: Peak of use:

Please list the substances, if any, that you feel have been an issue for you at some point:

With regard to these substances above that you listed, please check all that apply to you: *If positive responses for multiple substances, please place the first letter of the substance next to each of the relevant check boxes.*

- Used it in **larger amounts** than intended or **over a longer period** than intended
- Had a **desire** or **unsuccessful efforts** to cut down or control its use
- Spent **a lot of time** in activities to **get it, use it** or **recover** from it
- Had **cravings** or 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*)

ATTENTION

Please check all that 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.)
- 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 started before the age of 12
- These behaviors happen in 2 or more settings (i.e. School and home)

PERSONALITY FEATURES

Please check all that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Sensitivity to abandonment or rejection <input type="checkbox"/> Feelings of emptiness <input type="checkbox"/> Lots of drama in my relationships <input type="checkbox"/> Mood being really up and down even within the course of a single day <input type="checkbox"/> Issues with anger <input type="checkbox"/> Losing myself when in relationships (taking in their interests and dropping my own) <input type="checkbox"/> Impulsivity (with money, sex, job changes, alcohol, food, drugs, relationships) <input type="checkbox"/> Longstanding suicidal thoughts | <input type="checkbox"/> Longstanding history of self-harm <input type="checkbox"/> Need to inflate my sense of self-importance, often at other people's expense <input type="checkbox"/> Struggle to make decisions on my own, need to people please even when it is bad for me. <input type="checkbox"/> History of illegal activity (<i>15 yo or younger</i>) <input type="checkbox"/> Disregard for my own or other people's safety <input type="checkbox"/> Difficulty holding a job or honoring my commitments <input type="checkbox"/> Frequent lying to serve my needs <input type="checkbox"/> Repeated physical fights or assaults |
|--|---|

CURRENT MEDICATIONS *(Please answer the following to the best of your ability and leave unknown answers blank)*

| MEDICATION | DOSE | HOW LONG at this dose? | RESPONSE | SIDE EFFECTS |
|------------|------|------------------------|----------|--------------|
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DEVELOPMENTAL HISTORY *(Please check all that apply and provide details)*

- | | |
|--|--|
| <input type="checkbox"/> Issues when your mother was pregnant with you (physical abuse, health issues like drinking, illness)? <i>Please provide details:</i> <input type="checkbox"/> Complications at birth. <i>Please provide details:</i> <input type="checkbox"/> Health issues in the first few months after birth? <i>Please provide details:</i> | <input type="checkbox"/> Concerns about your development, like when you talked, walked, your coordination or social skills? <i>Please provide details:</i> <input type="checkbox"/> Difficulties with learning (i.e., Math difficulties, repeating a grade etc.) <i>Please provide details:</i> <input type="checkbox"/> Social difficulties? <i>Please provide details:</i> |
|--|--|

| ALLERGIES | PAST MEDICAL HISTORY | | | | | | | | | | | |
|--|--|---|---|---|---|-----------------------------------|--------------------------------------|---------------------------------------|---|---|---|--|
| <p><i>Please list any drug and non-drug allergies:</i></p> <p><input type="checkbox"/> No known drug or non-drug allergies</p> | <p>Please list any surgeries you have had: (<i>Wisdom teeth, Appendicitis, Gallbladder removal, C-sections, Hysterectomy, etc.</i>)</p> <p><input type="checkbox"/> No history of surgeries</p> | | | | | | | | | | | |
| PAST MEDICAL HISTORY | | | | | | | | | | | | |
| <p>Please check if you have a history of, or currently struggle with any of the following:</p> <table border="0"> <tr> <td><input type="checkbox"/> Anemia (low iron)</td> <td><input type="checkbox"/> Seizures</td> </tr> <tr> <td><input type="checkbox"/> Vitamin B12 deficiency</td> <td><input type="checkbox"/> Head injuries with loss of consciousness</td> </tr> <tr> <td><input type="checkbox"/> Low testosterone</td> <td><input type="checkbox"/> Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Sleep apnea</td> <td><input type="checkbox"/> Heart issues</td> </tr> <tr> <td><input type="checkbox"/> Thyroid problems</td> <td><input type="checkbox"/> Blood pressure</td> </tr> </table> | <input type="checkbox"/> Anemia (low iron) | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vitamin B12 deficiency | <input type="checkbox"/> Head injuries with loss of consciousness | <input type="checkbox"/> Low testosterone | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Heart issues | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Blood pressure | <p>Do you routinely see a doctor or NP for any other reason?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, please provide details:</p> | |
| <input type="checkbox"/> Anemia (low iron) | <input type="checkbox"/> Seizures | | | | | | | | | | | |
| <input type="checkbox"/> Vitamin B12 deficiency | <input type="checkbox"/> Head injuries with loss of consciousness | | | | | | | | | | | |
| <input type="checkbox"/> Low testosterone | <input type="checkbox"/> Diabetes | | | | | | | | | | | |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Heart issues | | | | | | | | | | | |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Blood pressure | | | | | | | | | | | |
| PAST MEDICATION TRIALS: | | | | | | | | | | | | |
| <p><i>Check all that apply and if possible, bring information about your max dose and duration of use to your appointment.</i></p> | | | | | | | | | | | | |
| <ul style="list-style-type: none"> <input type="checkbox"/> CipraleX/ Escitalopram <input type="checkbox"/> Celexa/ Citalopram <input type="checkbox"/> Prozac/ Fluoxetine <input type="checkbox"/> Zoloft/ Sertraline <input type="checkbox"/> Luvox/ Fluvoxamine <input type="checkbox"/> Paxil/ Paroxetine <input type="checkbox"/> Strattera/ Atomoxetine | <ul style="list-style-type: none"> <input type="checkbox"/> Fetzima/ Levomilnacipram <input type="checkbox"/> Effexor/ Venlafaxine <input type="checkbox"/> Pristiq/ Desvenlafaxine <input type="checkbox"/> Cymbalta/ Duloxetine <input type="checkbox"/> Trintellix/ Vortioxetine <input type="checkbox"/> Viibryd/ Vilazodone <input type="checkbox"/> Wellbutrin/ Bupropion | <ul style="list-style-type: none"> <input type="checkbox"/> Mirtazipine/ Remeron <input type="checkbox"/> Trazodone/ Desyrel <input type="checkbox"/> Elavil/ Amitriptyline <input type="checkbox"/> Desipramine/ Norpramin <input type="checkbox"/> Aventyl/ Nortriptyline <input type="checkbox"/> Anafranil/ Clomipramine <input type="checkbox"/> Tofranil/ Imipramine | | | | | | | | | | |
| <ul style="list-style-type: none"> <input type="checkbox"/> Imovane/ Zopiclone <input type="checkbox"/> Ambien/ Zolpidem <input type="checkbox"/> Ativan/ Lorazepam <input type="checkbox"/> Klonopin/ Clonazepam <input type="checkbox"/> Xanax/ Alprazolam | <ul style="list-style-type: none"> <input type="checkbox"/> Seroquel/ Quetiapine <input type="checkbox"/> Abilify/ Aripiprazole <input type="checkbox"/> Risperdal/ Risperidone <input type="checkbox"/> Zyprexa/ Olanzapine <input type="checkbox"/> Zeldox/ Ziprazidone <input type="checkbox"/> Latuda/ Lurasidone <input type="checkbox"/> Sapharis/ Asenapine | <ul style="list-style-type: none"> <input type="checkbox"/> Ritalin <input type="checkbox"/> Biphentin <input type="checkbox"/> Concerta <input type="checkbox"/> Dexedrine <input type="checkbox"/> Adderall XR <input type="checkbox"/> Vyvanse <input type="checkbox"/> Foquest | | | | | | | | | | |
| <ul style="list-style-type: none"> <input type="checkbox"/> Lamictal/ Lamotrigine <input type="checkbox"/> Lithium <input type="checkbox"/> Valproic Acid <input type="checkbox"/> Epival/ Divalproate | <ul style="list-style-type: none"> <input type="checkbox"/> Other psychiatric medication not listed: _____ | | | | | | | | | | | |

PAST THERAPY TRIALS

In the past, I have seen:

- Psychiatrist
- Psychologist
- EAP (Employee Assistance Program) or Social Work
- Outpatient Day Treatment Program (multidisciplinary team)
- Other (specify):
- I have a current therapist *please provide their name:*

For positive responses to above, in the past I have found therapy to be:

- Helpful
- Not helpful

APPROACH USED

- Don't know
- Supportive and/ or solutions/ problem-oriented
- Cognitive Behavior Therapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Eye Movement Desensitization Reprocessing Therapy (EMDR)
- Intensive Short Term Dynamic Psychotherapy (ISTDP)
- Dialectic Behavior Therapy (DBT)
- Emotion Focused Therapy (EFT)
- Marital Therapy

| FAMILY MEDICAL HISTORY (blood relatives only) | FAMILY PSYCHIATRIC HISTORY (blood relatives only): | | | | | | | | | | | | | | |
|---|--|------------------------------------|-------------------------------|-------------------------------------|--------------------------------------|----------------------------------|---------------------------------|---|---|--|---|---|---|------------------------------|--|
| <p>These illnesses run in my family (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease or sudden death at an early age <input type="checkbox"/> Cancer if so, which type: <input type="checkbox"/> Other: | <p>Please check all that apply for known family diagnoses:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Addiction</td> <td><input type="checkbox"/> PTSD</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> ADHD or ADD</td> </tr> <tr> <td><input type="checkbox"/> Bipolar</td> <td><input type="checkbox"/> Autism</td> </tr> <tr> <td><input type="checkbox"/> Social Anxiety</td> <td><input type="checkbox"/> Psychosis or schizophrenia</td> </tr> <tr> <td><input type="checkbox"/> Generalized Anxiety</td> <td><input type="checkbox"/> Early dementia (before 65)</td> </tr> <tr> <td><input type="checkbox"/> Panic Disorder</td> <td><input type="checkbox"/> Completed suicides</td> </tr> <tr> <td><input type="checkbox"/> OCD</td> <td></td> </tr> </table> | <input type="checkbox"/> Addiction | <input type="checkbox"/> PTSD | <input type="checkbox"/> Depression | <input type="checkbox"/> ADHD or ADD | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Autism | <input type="checkbox"/> Social Anxiety | <input type="checkbox"/> Psychosis or schizophrenia | <input type="checkbox"/> Generalized Anxiety | <input type="checkbox"/> Early dementia (before 65) | <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Completed suicides | <input type="checkbox"/> OCD | |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> PTSD | | | | | | | | | | | | | | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> ADHD or ADD | | | | | | | | | | | | | | |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Autism | | | | | | | | | | | | | | |
| <input type="checkbox"/> Social Anxiety | <input type="checkbox"/> Psychosis or schizophrenia | | | | | | | | | | | | | | |
| <input type="checkbox"/> Generalized Anxiety | <input type="checkbox"/> Early dementia (before 65) | | | | | | | | | | | | | | |
| <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Completed suicides | | | | | | | | | | | | | | |
| <input type="checkbox"/> OCD | | | | | | | | | | | | | | | |

*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. There are also various resources available that may be helpful. Should your symptoms worsen, please contact your GP or NP, present to the nearest Emergency room or contact the **Mobile Crisis Team at 902-429-8167** for assessment.*

Warmest wishes,
Dr. E. Adriana Wilson