INSPIRED LIVING MEDICAL
LIVE YOUR EPIC LIFE

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ELECTRONIC SERVICES & CORRESPONDENCE AGREEMENT

- Details regarding possible risks related to the provision of electronic services and/ or correspondence involving medical records are included at www.InspiredLivingMedical.com -> Services -> Psychiatry -> What can I expect?

- I understand and accept the risks associated with the use of electronic service provision and/or correspondence involving my medical records and reports with the clinicians and staff at Inspired Living Medical Inc.

- I acknowledge that despite reasonable efforts to protect the privacy and security of electronic communication or service provision, it is not possible to *guarantee* their security and confidentiality.

- I acknowledge and understand that it is possible that some of these services may not be encrypted.

- Despite these risks, I agree to engage and/ or communicate with the clinicians and staff by electronic methods with a full understanding of the risks, limitations and conditions involved.

- I acknowledge that either I or the physician may, at any time, withdraw the option of communicating or engaging electronically with written notice. Any questions I had have been answered.

Patient Name:_____DOB (MM/DD/YYYY): _____

Signature of Acknowledgement: _____

Date:_____

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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 to allow time to prepare for the assessment.

- Please send completed forms via e-mail attachment, by fax 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 the required time your appointment will be rescheduled. *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.*
- Although the form appears to be lengthy, much of it requires only check marks or a few words or yes/no answers, so it should not take 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 $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.

What to expect from the assessment:

- Appointments 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 physician who can follow up on any recommendations made.
- My practice offers one-time consultation and group therapy (only when indicated). I help you and primary health provider clarify diagnosis and create a treatment plan. Implementation and individual follow up happens with your GP or NP, in combination with the resources that are recommended.

NAME:	**DATE COMPLETED:**	**DOB** (YYYY/MM/DD):
Preferred Pronouns: ☐ **He/Him** ☐ **She/Her** ☐ **They/Them**		
Health Card #:	**Exp. Date:**	
Family Doctor's name:	**Phone number and Clinic Location** *(Family Doctor's)*:	

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

1. **I want help with:**
2. **So far I have tried:**
3. **These are the things that have been getting in the way:**
4. **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:**
- **I had/ have** *(#)* _____ **siblings.**
- **My caregivers supported us by** *(what did they do for work/income)***:**
- **I would describe my childhood as:**
- **My relationship with my siblings is** (if applicable**):**
- **My relationship with my parents is/ was:**
- **In my home growing up, conflict was handled by:**
- **In my home growing up, affection was shown by:**
- **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:**

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

MOOD

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

I noticed it changed (specify approximate date):

I think it changed because (specify reasons):

SLEEP

(Please check the most accurate answer)

- ☐ **I fall asleep quickly**
- ☐ **I usually fall asleep within 30 minutes of going to bed**
- ☐ **It takes 1h or more for me to fall asleep most nights**
- ☐ **It really varies from night to night**

I WAKE UP ☐ times/ night. When I do, I am usually up for ☐ (time).

- ☐ **I rarely wake up before 6 am and am up for the day**
- ☐ **I wake up before 6 am and am up for the day ☐ times/ week**

INTERESTS

What do you usually ENJOY doing?

- ☐ **I have been able to enjoy these things as usual lately**
- ☐ **I have NOT been able to enjoy these things as usual lately**

GUILT & NEGATIVE THINKING

- ☐ **I often get stuck in feelings of guilt or negative thinking**
- ☐ **I RARELY get stuck in feelings of guilt or negative thinking**
- ☐ **This is typical for me**

Compared to my normal, this is:

☐ Better ☐ Worse ☐ About baseline

If there has been a change, what do you think helped or made it worse?

ENERGY

Please rate your energy levels (1= low;10= high)

My recent energy levels are ☐/10

At baseline, my energy levels are ☐/10

My energy levels are usually

- ☐ **Similar to others my age**
- ☐ **Lower than others my age**

I exercise ☐ times/ week

Please describe how well you are functioning in the following domains compared to what is normal for you (i.e., better than your usual, worse than your usual, at your baseline):

- **Hygiene:**
- **Cooking :**
- **Housekeeping :**
- **Working: :**
- **Grocery shopping:**
- **Paying bills:**
- **Managing medications:**
- **Driving :**
- **Leaving the house:**

CONCENTRATION

Please rate your ability to pay attention and focus (1= low;10= very good)

Lately, my concentration levels are ☐/10

At baseline, my concentration levels are ☐/10

Please check all that apply:

- ☐ have a **known *or* suspected learning disorder**
- ☐ I have a **known diagnosis of ADHD or ADD**

APPETITE

Current height:

Current weight:

In recent months:

- ☐ gained weight
- ☐ lost weight
- ☐ eat 5+ servings of fruit or veg/ day

Lately my appetite is:

- ☐ Stable
- ☐ Variable
- ☐ Higher
- ☐ Lower
- ☐ Emotional eating/ out of boredom

RISK ASSESSMENT

Please check all that apply:

- ☐ **I have never wished for death or thought about ways I could kill myself**
- ☐ **I have had wishes for death**
- ☐ **I have thought of ways I could kill myself *(please specify plan and when):*** ☐
- ☐ **I have had one or more suicide attempts *(please specify how and when):*** ☐

For those with a positive response to the above:
In recent weeks, I think of suicide ☐ times/ week.

- ☐ **I have engaged in SELF HARM like cutting, burning, hitting yourself etc. *(if so, please indicate how and when):*** ☐
- ☐ **I have had thoughts of killing another person and actually planning their murder with the intent to act on it *(if so, please provide details):*** ☐
- ☐ **I have had current or past legal charges brought against me *(if so, please indicate when and what charges):*** ☐

HISTORY OF LOW MOOD

Please check all that apply:

- ☐ I have had **previous depressive episodes** (please specify how many and when):
- ☐ I have **missed school or work** as a result of not being able to function due to low mood.
- ☐ I have been **hospitalized in a psychiatric facility** (indicate dates, duration and city please): ☐

I have longstanding issues even at my baseline with:

- ☐ Low mood
- ☐ Sleep
- ☐ Appetite
- ☐ Energy
- ☐ Concentration
- ☐ Indecision
- ☐ Feelings of hopelessness (frequent)
- ☐ Self esteem

MANIA

Please check all that apply:

- ☐ **I have had periods of <u>4 consecutive days or more</u> when my mood was abnormally high or irritable <u>AND</u> you were only sleeping 2-3h/ night <u>AND</u> you did not feel tired <u>AND</u> were 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:
Please list here

If yes, which of the following are associated with worry for you:

☐ Feeling tense
☐ Difficulty concentrating
☐ Mind going blank
☐ Feeling irritable
☐ Sleep Issues
☐ Tired/ fatigue
☐ Feeling restless

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 positive, the panic was associated with:

☐ Feeling of impending doom
☐ Chest tightness
☐ Shortness of breath
☐ Stomach upset
☐ Numbness or tingling
☐ Sweating a lot

SOCIAL ANXIETY

Please check all that apply:

☐ feel **anxious** in **social situations**
☐ 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:

☐ worry **more than most** about my **physical health**
☐ am **easily alarmed** by **physical symptoms**
☐ This worry **interferes with my life**
☐ 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:

☐ have felt my life was threatened
☐ witnessed someone else's life be threatened
☐ 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):

☐ have intrusive thoughts, memories or dreams related to these/ this event(s)
☐ 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**:**

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

☐ **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:

☐ 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 <u>avoid</u> 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:

☐ Sensitivity to abandonment or rejection
☐ Feelings of emptiness
☐ Lots of drama in my relationships
☐ Mood being really up and down even within the course of a single day
☐ Issues with anger
☐ Losing myself when in relationships (taking in their interests and dropping my own)
☐ Impulsivity (with money, sex, job changes, alcohol, food, drugs, relationships)
☐ Longstanding 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 *(15 yo or younger)*
☐ Disregard for my own or other people's safety
☐ Difficulty holding a job or honoring my commitments
☐ Frequent lying to serve my needs
☐ Repeated physical fights or assaults

ADDITIONAL COMMENTS
(Please share anything we have not touched on and/or have family members or partners share their observations or concerns)

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

DEVELOPMENTAL HISTORY (*Please check all that apply and provide details*)

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

ALLERGIES

Please list any drug and non-drug allergies:

☐ **No known drug or non-drug allergies**

PAST MEDICAL HISTORY

Please list any surgeries you have had: *(Wisdom teeth, Appendicitis, Gallbladder removal, C-sections, Hysterectomy, etc.)*

☐ **No history of surgeries**

PAST MEDICAL HISTORY

Please check if you have a history of, or currently struggle with any of the following:

- ☐ Anemia (low iron)
- ☐ Vitamin B12 deficiency
- ☐ Low testosterone
- ☐ Sleep apnea
- ☐ Thyroid problems
- ☐ Seizures
- ☐ Head injuries with loss of consciousness
- ☐ Diabetes
- ☐ Heart issues
- ☐ Blood pressure

Do you routinely see a doctor or NP for any other reason?

- ☐ **No**
- ☐ **Yes,** *please provide details:*

PAST MEDICATION TRIALS: *Check all that apply and if possible, bring information about your max dose and duration of use to your appointment.*

- ☐ Cipralex/ Escitalopram
- ☐ Celexa/ Citalopram
- ☐ Prozac/ Fluoxetine
- ☐ Zoloft/ Sertraline
- ☐ Luvox/ Fluvoxamine
- ☐ Paxil/ Paroxetine
- ☐ Strattera/ Atomoxetine
- ☐ Fetzima/ Levomilnacipram
- ☐ Effexor/ Venlafaxine
- ☐ Pristiq/ Desvenlafaxine
- ☐ Cymbalta/ Duloxetine
- ☐ Trintellix/ Vortioxetine
- ☐ Viibryd/ Vilazodone
- ☐ Wellbutrin/ Bupropion
- ☐ Mirtazipine/ Remeron
- ☐ Trazodone/ Desyrel
- ☐ Elavil/ Amitriptaline
- ☐ Desipramine/ Norpramin
- ☐ Aventyl/ Nortriptaline
- ☐ Anafranil/ Clomipramine
- ☐ Tofranil/ Imipramine
- ☐ Imovane/ Zopiclone
- ☐ Ambien/ Zolpidem
- ☐ Ativan/ Lorazepam
- ☐ Klonopinl/ Clonazepam
- ☐ Xanax/ Alprazolam
- ☐ Seroquel/ Quetipaine
- ☐ Abilify/ Aripiprazole
- ☐ Risperdal/ Risperidone
- ☐ Zyprexa/ Olanzapine
- ☐ Zeldox/ Ziprazidone
- ☐ Latuda/ Lurasidone
- ☐ Sapharis/ Asenapine
- ☐ Ritalin
- ☐ Biphentin
- ☐ Concerta
- ☐ Dexedrine
- ☐ Adderall XR
- ☐ Vyvanse
- ☐ Foquest
- ☐ Lamictal/ Lamotrigine
- ☐ Lithium
- ☐ Valproic Acid
- ☐ Epival/ Divalproate

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)*:*
These illnesses run in my family *(check all that apply):* ☐ Diabetes ☐ Heart disease or sudden death at an early age ☐ Cancer *if so, which type:* ☐ ☐ Other**:** ☐	***Please check all that apply for known family diagnoses:*** ☐ Addiction ☐ Depression ☐ Bipolar ☐ Social Anxiety ☐ Generalized Anxiety ☐ Panic Disorder ☐ OCD ☐ PTSD ☐ ADHD or ADD ☐ Autism ☐ Psychosis or schizophrenia ☐ Early dementia (before 65) ☐ Completed suicides

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