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: _____

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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 at the time of virtual appointments.
- *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 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 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: **Preferred Pronouns:** ☐ **He/Him** ☐ **She/Her** ☐ **They/Them**	**DATE COMPLETED:** | **DOB** (YYYY/MM/DD):
Health Card #:	**Health Card Expiry Date:**
Family Doctor's name:	**Phone number and Clinic Location** *(Family Doctor's)*:
Your Preferred Appointment type: *(If you choose virtual & in-person, you will be scheduled for whichever is earlier.)* ☐ **In-Person** ☐ **Zoom Video Call*** ☐ **Telephone Call*** *If virtual, please review the virtual consent video on our website (www.InspiredLivingMedical.com/Intake): ☐ **I have watched the video and consent to virtual care**	**Appointment Reminder will be sent via** *(please choose only one):* ◯ **Email** ◯ **Text message** ◯ **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:

- ☐ 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

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

- ☐ Lamictal/ Lamotrigine
- ☐ Lithium
- ☐ Valproic Acid
- ☐ Epival/ Divalproate

- ☐ Seroquel/ Quetipaine
- ☐ Abilify/ Aripiprazole
- ☐ Risperdal/ Risperidone
- ☐ Zyprexa/ Olanzapine
- ☐ Zeldox/ Ziprazidone
- ☐ Latuda/ Lurasidone
- ☐ Sapharis/ Asenapine

- ☐ Ritalin
- ☐ Biphentin
- ☐ Concerta
- ☐ Dexedrine
- ☐ Adderall XR
- ☐ Vyvanse
- ☐ Foquest

☐ 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)

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**:** _____

FAMILY PSYCHIATRIC HISTORY (blood relatives only)*:*

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