Dr. KAMRAN BORDBAR, MD, FRCP(C)
1100 SHEPPARD AVENUE EAST, SUITE 401, TORONTO, ON M2K 2W1
Phone: 416-548-9701, Fax: 416-548-9702

Intake Form – Psychiatry

Patient Information		**Date:** *yyyy-mm-dd*	
First Name	*Middle Name*	*Last Name*	
Date of Birth	*Age*	*Ethnic Origin*	*Gender:* O Male O Female
OHIP Card Information	*Number-Version Code*		Expiry
Emergency Contact	*Name*	*Relationship*	Phone
Referring Source			
Name	*Title/Position/GP/Specialist*	*Phone*	Fax
Address			
City	*Province*	*Postal Code*	
Who is filling this form	O Patient O Spouse	O Parents	O Other:
Name	*Title/Position/GP/Specialist*	*Phone*	*Work/Cell*
Address			
City	*Province*	*Postal Code*	
Who else will be coming to this assessment			
Name 1	*Title/Position/Relationship*	*Name 2*	*Title/Position/Relationship*
Name 3	*Title/Position/Relationship*	*Name 4*	*Title/Position/Relationship*
Living Situation			
O Home	O Foster Home	O Group Home	O Other
Address			
City	*Province*	*Postal Code*	O House O Apartment
Who else lives at home	*Name 1*	*Relationship*	*Age*
	Name 2	*Relationship*	*Age*
	Name 3	*Relationship*	*Age*
	Name 4	*Relationship*	*Age*
	Name 5	*Relationship*	*Age*
Custody Status (<16)	O Full	O Joint	O Other
Marital Status (>16)			
O Common Law	O Separated	O Single	O Same Sex Partner
How long - Dates	*How long - Dates*	*How long - Dates*	*How long - Dates*
O Married	O Divorced	O Widowed	O Other
How long - Dates	*How long - Dates*	*How long - Dates*	*How long - Dates*
Spouse/Partner	**Current**	**Previous - In contact**	**Previous - Not in contact**
O Not applicable	*Relationship Type*	*Relationship Type*	*Relationship Type*
	Name	*Name*	*Name*
	Phone	*Phone*	*Phone*
	Cell	*Cell*	*Cell*

Reason for Referral	
Whose idea was it to arrange for this assessment?	O Not Sure O Doctor O Patient O Family O School O Work
Please explain	
What is the main purpose for this assessment?	O Not Sure O Diagnosis O Treatment O Second Opinion
Please explain	
What are the main concerns/problems at this time?	O Not Sure O No concern/problem O Other
Please explain	
What is hoped to be achieved, improved or changed?	O Not Sure O No goal O Other
Please explain	
What type of help is being sought?	O Not Sure O Medication O Counselling O Other
Please explain	

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Occupation	
Employer/School Name	

Family Contacts (parents, siblings, children)

Professional Contacts (Physicians, therapists, agencies)

Medical / Surgical / Psychiatric History

Medication History: Prescription / Non-Prescription (Over the Counter)**– Current & Past** (name, dosage, dates)

Hospitalization / Injuries / Accidents / Abuse History

Allergies (Drugs / Food / Environment - Type of Reaction: Allergy or Side Effect)

Family Medical / Surgical / Psychiatric History