

Date: _____

Client name: _____
(Surname) (First Name)

DOB: _____
(Month/Day/Year)

Address: _____

Postal Code: _____

Telephone: _____ Email: _____

In case of emergency Please notify: _____ Phone: _____

PROFESSIONAL SUPPORT

Psychiatrist: _____

phone: _____

Physician: _____

phone: _____

Case Manager: _____

phone: _____

Other: (please specify): _____

phone: _____

MEDICAL INFORMATION

AXIS 1: _____

AXIS 2: _____

AXIS 3: _____

AXIS 4: _____

Any adverse side effects from prescribed medications?: _____

Distress signals: _____

HISTORY AND BACKGROUND INFORMATION

Psychiatric hospitalizations (date, duration, reason): _____

Past suicide attempts: Yes No If yes, please describe: _____

Current active or passive suicidal ideation: Yes No If yes, attach most recent risk assessment and/or safety plan: _____

Alcohol/substance use past and present (and stage of change):

Is there a history of violence or aggression Yes No If yes, please describe:

Behavioural issues: _____

ADL's/IADL's: _____

Concurrent Programming: _____

SPECIFIC GOALS FOR PARTICIPATION IN A PSYCHOSOCIAL REHABILITATION PROGRAM:

REFERRED BY: _____ Telephone #: _____

Signature and title of Referring Agent: _____

Please return or fax attention: GROW | 125 Skinner Street | (Fax) 250-389-1263