Alberta Health Services

Affix patient label within this box

Intake Questionnaire
Developmental Disabilities Mental Health

Date *(yyyy-Mon-dd)*		
Completed By	Position	Completed *(yyyy-mon-dd)*

Other Support Services (e.g. psychologists) other than contacts listed on Patient Contact Information.

Name	Agency	Phone	Service Provided

Current Concerns/Chief Complaint

Briefly state why this person is being referred for psychiatric evaluation. What assistance are you seeking regarding these concerns?

Duration of Current problems

☐ 1 – 3 months ☐ 3 – 6 months ☐ 6 – 12 months ☐ 12 + months

Family History or Mental Illness, Developmental Disabilities, Neurological Illness or Seizures

List biological relatives who have a history of mental illness, mental handicap developmental disability, neurological illness or Seizures. This includes suicide attempts, severe substance abuse, psychiatric hospitalization and or treatment

☐ No information available

Relationship to Client	Illness	Treatment Date

Pregnancy and Delivery

☐ No information available Duration of Pregnancy *(in months)* _____

During pregnancy was alcohol, drugs or medications used?

☐ Don't know ☐ No ☐ Yes ▶ _____

Birth weight _____ lbs _____ oz	Apgar Score ☐ 1 minute ☐ 5 minutes
Delivery ☐ Spontaneous ☐ Induced ☐ Caesarean	Complications for pregnancy or delivery ☐ No ☐ Yes ▶ _____

Early Development

Milestones ☐ No information available

Sat Up	Walked	1st word	Talked (Phrase)	Trained Urine	Trained Feces

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Any unusual speech problems: Describe

_____

_____

Mental Handicap Diagnosis: ☐ No information available

Age when diagnosis first made _____

Cause of mental handicap *(if known)* _____

Has genetic testing been done? ☐ No ☐ Yes Date *(yyyy-mon-dd)* _____

Results _____

Developmental Disability Information ***(Please enclose a copy of any testing, if available)***

IQ Testing Full Scale Score _____ ☐ No information available

Other testing (Adaptive, speech language, physiotherapy, Ocuupational Theraphy, etc)

Test Administered	Date	Examiner	Results	

Has the client been diagnosed as suffering from an Autism spectrum disorder?

☐ No ☐ Yes *(if available please enclose report)*

Educational History

List school attended ☐ No information available

Name	Grade Attended	Comments

Residential/Institutional Placements

List previous residential placements

Agency	Admission Date	Discharge Date	Comments

Respite Care ☐ No ☐ Yes Frequency _____

Vocational placements

List previous vocational placements or day programs

Agency	Admission Date	Discharge Date	Comments

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Medical History	No	Yes	Describe
Seizure Disorder	☐	☐	
Abnormal EEG	☐	☐	
CT Scan	☐	☐	
MRI	☐	☐	
Tics or Tremors	☐	☐	
Any other type or neurological troubles e.g., headaches	☐	☐	
Specific communication disorder (e.g., inability to talk)	☐	☐	
Heart problem	☐	☐	
Respiratory problem (eg. Asthma)	☐	☐	
Stomach or intestinal problems	☐	☐	
Gynecological problems	☐	☐	
Urinary problems	☐	☐	
Skin problems	☐	☐	
Orthopedic problems	☐	☐	
Arthritis	☐	☐	
Allergies	☐	☐	
Impaired vision	☐	☐	
Impaired hearing	☐	☐	

Past Hospitalizations (Psychiatric/Medical/Surgery)

Date	Name of Hospital	Describe Surgery or Reason for Hospitalization

Current Physical and Mental Function
Consider the previous 3 months in completing this inventory

Physical Function	Concerns
Sleep	
Appetite	
Mood	
Thoughts (Unusual)	
Aggression	
Energy Level	
Concentration Ability	
Bowel and Bladder Concerns	
Menstrual Concerns	
Sexuality	

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Current Medications					
Medications	**Dose**	**Times/ Day**	**Effect**	**Prescribing Physician**	**Date Started**

Previous Trials of Medications				
Medications	**Dose**	**Start Date**	**End Date**	**Describe Result**