Robin Beardsley MD CCFP
from striving **to thriving**

robinbeardsleymd.ca

Confidential Intake Questionnaire for Support

Instructions: Print and complete this form, fax it to 613-595-1600 prior to your first appointment.
NOTE: * (indicates required fields)

Patient Information

First Name:* _____ Last Name:*_____

Address: _____ Apt#: _____

City: _____ Province: _____

Postal Code: _____ Email: _____

Phone w/ extension if applicable:* _____ Is your phone textable? Yes____ No____

Date of Birth:* _____ Occupation: _____

How did you hear about Dr. Beardsley? CPSO____ Friend____ Website____ Other_____

In Case of Emergency - Contact Information

Name: _____ Relationship: _____

Phone: _____ Email: _____

Working with Dr. Robin Beardsley

What do you see as the issues you are working on? (Please be as specific as possible.)

What are you hoping to change by working with Dr. Beardsley?

Health Concerns

What stressors are you currently managing?

☐ Job stress ☐ Financial Concerns ☐ Family Concerns ☐ Parenting Concerns

☐ Major Life Changes

What Physical Symptoms are you currently experiencing?

What Emotional Symptoms are you currently experiencing?

☐ Feeling Overwhelmed ☐ Anger Issues ☐ Loss ☐ Anxiety ☐ Lack of Energy ☐ Depression

☐ Feeling Uncertain ☐ Addiction ☐ Feeling "Disconnected"

What is it that impacts you the most? How does it present or show up in your life?

How would you like things to be? *Think of* what you want rather than what you don't want, or think of what you might need?

Describe the Positive Outcomes that you will experience in your life as a result of creating some changes.

What significant health challenges have you experienced in the past?

What significant emotional challenges have you experienced in the past?

☐ Anxiety ☐ OCD ☐ Addiction ☐ Frequent Moves ☐ Loss of a Loved One ☐ ADHD

☐ Childhood Abuse ☐ Eating Disorder ☐ Parent's Divorce ☐ Learning Disability

☐ Significant Accident or Illness

Family Physician: _____

Allergies:

Present Medication(s):

Current Medication	Dose	Frequency	Date Started

Past Medication(s):

Past Medication	Dose	Frequency	Dates of Use

Past Medication(s): continued

Past Medication	Dose	Frequency	Dates of Use

Past Treatment for Mental Health Issues? Yes or No. If yes, please describe.

Additional Information / Comments?
