Kenora Association for Community Living
A Meaningful and Satisfying Life

Community Mental Health Support Services
Dual Diagnosis Intake Form

Name:_____ Date of birth:_____ ◯ Male ◯ Female

Address:_____

Home phone:_____ Health card #:_____

Method of communication: ◯ verbal ◯ sign language ◯ augmented communication type

What is your first language? ◯ English ◯ French ◯ Ojibway ◯ Other

Confirmed intellectual disability? If yes, please indicate the etiology if known, date of diagnosis and diagnostician.

_____

_____

Confirmed mental illness diagnosis? If yes, please indicate illness, date of diagnosis, and diagnostician.

_____

_____

Referral source:_____
(Name) (Address) (Phone)

Family doctor:_____
(Name) (Address) (Phone)

If Applicable:
Substitute decision maker: _____
(Name) (Relationship)

Individual Information

Please attempt to complete the following section with the person being referred.

Tell us about yourself, including your best liked qualities, talents, and strengths.

_____

_____

_____

Please describe your living situation: (type of dwelling, roommates if any, support arrangements in place, other important information).

_____

_____

_____

Do you work or go to school?

_____

_____

_____

Who are the important people in your life?

_____

_____

Present Symptoms of Concern

This section is at times directed towards the person being referred.

Describe in detail the current concerns:

_____

_____

_____

_____

_____

_____

_____

When are the symptoms of concerns better/worse?

- Consider when other people are around, and who, the environment, seasonally, and post-partum and/or menstrual cycle (where applicable).

_____
_____
_____
_____
_____

What has been helpful to date?

_____
_____
_____
_____
_____
_____

Is there a behaviour you would like to see change?

_____
_____

Please indicate if any of the following symptoms have been experienced and/or observed, and explain in the space provided:

- ☐ Sleep disturbances: _____
- ☐ Change in energy level: _____
- ☐ Change in appetite: _____
- ☐ Chronic pain: _____
- ☐ Difficulty with daily living skills: _____
- ☐ Anxiety and/or panic attacks: _____
- ☐ Difficulty concentrating: _____
- ☐ Concerning physical movements: (ie. tics) _____
- ☐ Rituals or compulsive acts: _____
- ☐ Frequent sadness, or elevated mood:_____

Have you had thoughts of self-harm?

_____

_____

Have you had thoughts of hurting someone else?

_____

_____

Have you attempted to hurt someone else?

_____

_____

Do you experience hallucinations or have others suggested to you that this may be happening? (seeing, hearing, smelling, tasting, or feelings that are not observable by anyone else):

_____

_____

_____

Have others told you that you have delusions (strong beliefs that are not based on reality)?

_____

_____

Past Psychiatric History

Have you been in a psychiatric hospital? If so, please list below:

Facility Name	Date	Treatment	Length of Stay

**** Please provide any summary reports or notes from previous psychiatric hospitalizations****

Current and Past Medication

Please list all of your **CURRENT** medications, including over the counter, vitamins, supplements, and herbal:

Medication Name, Dosage and Route Administered	Reason	Date Prescribed

****Please attach any blood test records completed in the last three months and any other observational/side effect/symptom monitoring charting already in place****

Please list all of your **PAST PSYCHOTROPIC** medications:

(psychotropic: relating to drugs that affect a person's mental state)

Medication Name, Dosage, and Route Administered	Date Prescribed	Date Discontinued, and Reason

Medical Information and History

Height: _____ Weight: _____

Do you have any allergies? (food, medications, environmental etc.) If so, please list:

_____

_____

_____

Do you experience any type of seizures? If so, please describe type and frequency:

_____

_____

**** If possible, please include any neurological consult notes and results****

Do you have heart problems? ◯ No ◯ Yes

If yes, please describe:

_____

Respiratory problems? ◯ No ◯ Yes

If yes, please describe:

_____

Do you experience stomach/intestinal problems? ◯ No ◯ Yes

If yes, please describe:

_____

Do you have gynecological or urinary problems? ◯ No ◯ Yes

If yes, please describe:

_____

Are there any skin problems? ◯ No ◯ Yes

If yes, please describe:

_____

Do you have orthopedic problems? ◯ No ◯ Yes

If yes, please describe:

_____

Vision or hearing impaired? ◯ No ◯ Yes

If yes, please describe:

_____

Are there any known thyroid problems? ◯ No ◯ Yes

If yes, please describe:

_____

Are there any known dental problems? ◯ No ◯ Yes

If yes, please describe:

_____

****Please attach any other relevant lab reports, x-ray, EEG, medical assessments, and psychiatric assessments, if available.****

Family History

Is there family history of mental illness, intellectual disabilities, autism spectrum disorders, or neurological disorders?

◯ No ◯ No information available ◯ Yes

If yes, please list all biological relatives who have a history of mental illness, intellectual disability or neurological disorder.

Relationship to Client	Diagnosis	Comments

Substance Use

Are there problems with substance use currently or in the past? ◯ No ◯ Yes

If yes, please indicate which substances have been problematic, and their frequency of use:

- ☐ Alcohol: _____
- ☐ Marijuana: _____
- ☐ Methamphetamine: _____
- ☐ Cocaine or Ecstacy:_____
- ☐ Opiods (e.g. hydromorphone, heroin) : _____
- ☐ Solvents: _____
- ☐ Hallucinogens (e.g. LSD, PCP): _____
- ☐ Other: _____

Legal History

Current Legal status: ◯ No legal problems ◯ Civil ◯ Criminal

Current legal status continued:

◯ In custody ◯ Awaiting sentence ◯ Awaiting trial
◯ On probation ◯ Conditional sentence ◯ On parole
◯ Restraining order ◯ Unfit to stand trial ◯ Not criminally responsible
◯ Conditional discharge ◯ Charges withdrawn ◯ Peace bond
◯ Court diversion ◯ Bails Supervision Program ◯ Bails Residency Program

Past legal charges or concerns:

_____

_____

_____

Developmental History

****Please attach childhood welfare agency social history if applicable.****

Where were you born?_____

How long was your mother pregnant before giving birth to you?

Duration (in months):_____

Were there complications during the pregnancy: ◯ No ◯ Yes

If yes, please describe:

_____

_____

Delivery: ◯ Spontaneous ◯ Induced ◯ Caesarean

Complications at delivery: ◯ No ◯ Yes

If yes, please describe:

_____

_____

Birth Weight ____lbs _____oz Apgar Score _____

Please indicate, at what age, each of these milestones were reached.

Sat up: _____ Walked: _____ Talked: _____

Toilet Trained: _____ Puberty: _____

Father's name:_____ ◯ In contact ◯ No involvement ◯ Deceased

Mother's name: _____ ◯ In contact ◯ No involvement ◯ Deceased

Sibling name :_____ ◯ In contact ◯ No involvement ◯ Deceased

Sibling name :_____ ◯ In contact ◯ No involvement ◯ Deceased

Sibling name :_____ ◯ In contact ◯ No involvement ◯ Deceased

Sibling name :_____ ◯ In contact ◯ No involvement ◯ Deceased

Sibling name :_____ ◯ In contact ◯ No involvement ◯ Deceased

Please describe your relationship with your parents:

_____

_____

_____

If applicable, please describe your relationship with your siblings:

_____

_____

_____

Do you have children? ◯ No ◯ Yes

If yes, please list their names, ages, and describe your relationship:

_____

_____

_____

Education History

What is the highest level of education you have completed?

_____

_____

_____

Residential and Significant Life History

Please list, in chronological order, any significant life events:

Some events to consider are listed below:

- Developmental milestones
- Record of moves
- Unusual childhood illness
- Death of a loved one
- Marriage/Divorce
- Psychiatric hospitalizations
- Transitions in school or home
- Early intervention programs
- Age of puberty
- Stay at residential programs
- Psychotropic drug therapy
- Police involvement

Approximate Age	Significant Life Event

If anything important was missed in the questioning please feel free to add concerns, comments, and/or questions here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Collateral Checklist:

Please consider the following documentation and indicate if it is included, or not applicable (N/A):

	Social History
	Psychiatric assessments
	Psychological consultations
	Hospital discharge summaries
	DSO assessment (e.g. Assessor Summary Report)
	Bloodwork (completed in the last three months)
	Current support plans
	Current safety plans
	Current tracking in place