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Mindfulness Based Cognitive Therapy

Patient Intake Form

Hannah Snider MD, CCFP

Thank you for taking the time to complete this questionnaire. The information below helps to evaluate whether this course is appropriate for you at this time in your life. All information will be kept confidential. If you are confused about a question, feel free to leave it blank. We will review this questionnaire during your pre-session appointment.

Patient Information

Date: _____

Name (as it appears on your Health Card): _____

Health Card Number (including the version code)
_____

Home address (in full): _____
_____

Date of Birth (MM/DD/YY): _____ Age: _____

Phone number:
Cell: _____ Home: _____ Work:_____

E-mail Address: _____

Occupation and/or source of income:
_____

Emergency Contact Name & Phone Number:
Name: _____
Relation: _____ Phone: _____

Family Physician: _____

Do you give consent for Dr. Snider to speak with your family physician if deemed necessary or helpful? Yes _____ No _____

Signature _____

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Intentions/Goals

How did you hear about this program?

Why have you decided to take this program? What do you hope to learn?

Mental Health History

Do you have a past or current history of depression, anxiety, eating disorder, bipolar disorder, obsessive-compulsive disorder, schizophrenia, ADHD or any other mental health concern? If yes, please specify.

What symptoms of the above bother you most? If you have not been diagnosed with any of the above, please list your most bothersome symptoms:

How do you feel you are managing currently?

Do you have current or past thoughts of self-harm or suicide? Please explain if you feel comfortable.

Do you have thoughts of harm to others? Yes _____ No _____

What do you feel were/are the contributing factors to episodes of depression/anxiety/stress?

Do you have experience with CBT (cognitive behavioural therapy) or meditation? Please explain.

Do you have an active (ongoing) therapeutic relationship with your family doctor or a counselor/therapist?

Do you have a family history of mental illness or substance abuse (depression, anxiety, 'mental breakdown', schizophrenia, bipolar disorder, alcoholism)? If yes, please specify.

Have you ever been diagnosed with PTSD (post traumatic stress disorder)?
Yes _____ No _____

Have you experienced family crisis or trauma, including death, car accident, past physical, sexual or emotional abuse, separation or divorce?
Yes_____ No _____

Are you comfortable discussing this at your appointment?
Yes_____ No _____

If yes, have you been in counseling or through a healing process to work through previous trauma?
Yes_____No____

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Social History

What is your current greatest stressor?

What have been the most stressful/difficult experiences in your life?

1.
2.
3.
4.
5.

What is the greatest impact that stress has on your life?

Who are your social supports in your life?

Who is part of your family? Briefly describe your relationship with members of your family of origin and your current family (however you define this – eg spouse, children, etc):

FAMILY OF ORIGIN:

CURRENT FAMILY:

Did you grow up with a particular religious or spiritual tradition? If yes, please explain.

Do you currently identify with any religious or spiritual tradition or practice? If yes, please explain what this means to you.

Medical History

Please list any current or past medical health issues (including head injuries and/or seizures):

Please list your current medications (prescription and supplements/herbal/OTC):

Please list any known allergies:

Do you drink coffee or other caffeinated substances? Yes ___ No ___
If yes, how many per day? ____

Do you smoke? Yes___ No___

Do you drink alcohol? Yes ___ No ___
If yes, how many drinks on average per week?_____

Do you use marijuana or any other drugs/substances? Yes___ No____
If yes, please list:

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Has your doctor ever cautioned you about participating in any form of physical activity?
Yes_____ No_____

If yes, please explain:

Indicate any restrictions you might have doing any of the following exercises:

Sitting or lying on floor _____

Balancing exercises_____

Walking_____

Other_____

Given that the experience of practicing mindfulness is essential to acquiring benefits from this course, it is important to think about the time you are willing to commit to this process.

Do you feel you are able to commit to attending all 8 sessions, the Saturday Mindfulness Day, as well as commit to completing the home practices (approximately 30-60min per day)?

YES _____
NO _____
Unsure _____

Please explain:

Is there anything else you want me to know?

Please also complete the following forms (in subsequent pages) and bring them to your appointment:

1) Cancellation Policy form
2) Email Consent Form

I look forward to meeting with you soon.

Dr. Hannah Snider

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True Wellness Integrative Health Centre
48 hour Cancellation/Missed Appointment Policy

Dr. Snider's appointment fees are covered through OHIP. However, missed appointment fees apply if an appointment is missed or cancelled with less than 48 hours notice.

This policy is in place out of respect for the provider and other patients. Cancellations with less than 48 hours notice are difficult to fill. By giving last minute notice or none at all, you prevent someone else from being able to schedule into that time slot.

The following fees will apply for missed or cancelled appointments with less than 48 hours notice:

30 min appointment: $60
60 min appointment: $120
75 min appointment: $180

Cancellation fees will only be waived on compassionate grounds, such as in the event of a medical emergency requiring urgent professional treatment, death in the family, or in dangerous weather conditions.

Multiple missed office appointments will result in Dr. Snider no longer being able to see you.

Thank you for your understanding and cooperation.

Acknowledgement of Policy

I, _____ (print name), have read the True Wellness Integrative Health Centre Cancellation/Missed appointment Policy. I understand that I am responsible for the above listed fees if I do not provide 48 hours cancellation notice.

Printed Name of the Patient Date

Signature of Patient Date

True Wellness Integrative Health Centre
Consent to Email Communication (2 pages)

True Wellness Integrative Health Centre, and occasionally Dr. Hannah Snider use email as a form of communication with clients/patients. For the most part, this will be for scheduling purposes, reminders, and possibly for checking in on patient well-being. Your acknowledgement of the potential risks, along with your consent, is required to communicate in this way. Transmitting information via email poses several risks of which you should be aware. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.
- Encryption software is not available to be used for communication.

Conditions of using email

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the physician. Thus, patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- The physician may forward emails internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, health care operations, and other handling. The physician will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although the physician will endeavour to read and respond promptly to an email from the patient, **the physician cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time-sensitive matters.**
- Email communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up on the physician's email and for scheduling appointments where warranted.
- If the patient's email requires or invites a response from the physician and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- **The patient agrees to contact their family physician if they have medical concerns, including a decline in mood or thoughts of suicide throughout the duration the MBCT course or while**

under the care of Dr Snider. The patient understands that the physician will not be available in a timely manner to respond to concerns via email.

- The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.
- The patient is responsible for informing the physician of any types of information the patient does not want to be sent by email, in addition to those set out in the bullet above. Such information that the patient does not want communicated over email includes: _____ _____ _____ The patient can add to or modify this list at any time by notifying the physician in writing.
- The physician is not responsible for information loss due to technical failures.

Instructions for communication by email

To communicate by email, the patient shall:

- Limit or avoid using an employer's computer.
- Inform the physician of any changes in patient's email address.
- Include in the email: the category of the communication in the email's subject line, for routing purposes (e.g., 'prescription renewal'); and the name of the patient in the body of the email.
- Review the email to make sure it is clear and that all relevant information is provided before sending to the physician.
- Inform the physician that the patient received the email.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the physician.
- **Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email.** Rather, the patient should call their family physician's office for consultation or an appointment, visit the physician's office or take other measures as appropriate.

Patient acknowledgement and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Physician and me, and consent to the conditions outlined within these three pages, as well as any other instructions that the Physician may impose to communicate with patients by email. I acknowledge the Physician's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient Name: _____

Patient email: _____

Patient signature: _____Date:_____

I agree to waive the encryption requirement, with the full understanding that such a waiver increases the risk of violation of my privacy.

Name _____

Signature _____

Date _____