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Patient Intake Form
(Paper Alternative to Online Intake Forms)
Hannah Snider MD, CCFP

Drop off, mail or Fax to Hannah Snider MD (c/o True Wellness Integrative Health Centre)
25 Bruce St. Kitchener, ON N2B 1Y4
Fax: 519-745-1605

Thank you for taking the time to complete this questionnaire. The information below helps to gather a comprehensive physical, mental, and stress history.

Please indicate which service you are interested in:
_____Mindfulness Based Cognitive Therapy (MBCT): OHIP covered group psychotherapy
_____Functional Medicine (non-insured service)
_____Both

Your first appointment will be OHIP covered. If you are interested in MBCT, the appointment will help explore whether this program is appropriate for you given your present concerns. If you are interested in Functional Medicine, this appointment will serve as an initial health history overview, exploring the nature of chronic symptoms, stress and your goals.

Looking forward to meeting with you soon.

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: _____

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Occupation and/or source of income:
_____

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

Family Physician and address/phone number: _____
_____

Intentions/Goals

What are your goals from meeting with Dr. Snider?

Medical History

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

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

Please list any known allergies:

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Mental Health History

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

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____

Most Bothersome Symptoms

Please explain your most bothersome symptoms:

How do you feel you are managing currently?

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?

Childhood History

Please briefly describe your childhood experience (who did you live with, what was life like growing up for you)?

Relationships

Please circle one or more of the following: Married/Single/Common-law/divorced/long-term relationship/new relationship

Please describe who lives with you (including pets) and quality of the relationships in your household:

Who are your social supports in your life?

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.

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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:

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_____

Is there anything else you want Dr. Snider to know?

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

1) Cancellation Policy form
2) Email Consent and Acknowledgement of Services Form
3) MBCT Informed Consent Form (if participating in MBCT)

We look forward to seeing you soon.

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Hannah Snider MD
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

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Consent to Email Communication, Acknowledgment of Services

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 wellbeing. 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 and staff may forward emails internally 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 _____

Acknowledgement of Dr. Snider's Services

I acknowledge and understand that Dr. Snider does not provide primary care and is in the office at most two days per week. If I have medical concerns or acute mental health concerns including worsening mood or increasing thoughts of suicide, I agree to contact my family physician's office or proceed to Grand River Hospital Emergency Department. I also understand that Dr. Snider rents space from True Wellness, and that she may not necessarily endorse the treatments or products displayed or recommended by other practitioners at True Wellness.

Patient Name: _____

Signature: _____ Date: _____

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INFORMED CONSENT
MINDFULNESS BASED COGNITIVE THERAPY (MBCT) GROUP PSYCHOTHERAPY
With Dr. Hannah Snider, Family Physician focusing in Psychotherapy

This form is intended to provide you with information necessary for you to make a decision whether this group psychotherapy program is right for you. Please read through this form prior to your appointment with Dr. Snider. You will have an opportunity to ask questions at your intake appointment, and will be invited to sign this at your appointment if you wish to move forward with the program.

Dr. Snider is a Family Physician with a focused practice in psychotherapy. As a medical doctor, she is required to complete a medical assessment of your mental status, your behaviour, and your personality. This includes a diagnosis and treatment plan. This is all part of your medical record.

Any information shared with Dr. Snider will be held confidentially. However, there are certain circumstances where mandatory reporting applies. These include: Threat of imminent life-endangering harm to self or others, suspected child abuse, patient report of sexual abuse by a healthcare professional, unsafe to drive a motor vehicle or airplane, reportable infectious disease, or a court order.

MBCT Program.

The MBCT program includes an individual assessment to determine if this program is appropriate for you (and for you to determine whether it is what you are looking for), 8 group sessions as well as a Saturday Mindfulness Day. It also includes one individual follow up session with Dr. Snider after the program finishes. The program itself includes skill training in meditation and basic movement (basic yoga postures and mindful walking). I understand this movement is low risk, and I agree to assume this risk and understand that I should consult my family physician if I have any concerns about these components.

I will be invited to open more fully to the pleasant AND the unpleasant experiences of life. Though mindfulness meditation is generally understood to be very low risk, turning to face the difficulties within ourselves can often be challenging. It is uncommon, but there have been reports of mental health decline associated with meditation.

I understand that, if for any reason I am unable to, or think it unwise to engage in these activities, techniques and exercises, either during the weekly sessions at the MBCT program, or at home, I am under no obligation to engage in these techniques. The program is designed to help me to learn these skills appropriately and to never engage beyond my capabilities.

I am aware that MBCT is not a substitute for medical care or individual psychotherapy. If it is appropriate for medical or psychotherapeutic reasons, I have consulted with my physician and/or my therapist about my ability to participate in this program. I have appropriate emotional supports for the duration of the program. I have provided Dr. Snider with the relevant information about my medical and psychotherapeutic care.

I understand that I am expected to attend all of the 8 weekly sessions as well as a retreat and also to practice the homework assignments as suggested, appropriate to my abilities, for the duration of the program.

I understand that by participating in this program, some of my personal health information (through what I choose to share) will be revealed to others in this group. I voluntarily accept this, and give my consent to participate in this group psychotherapy program. The risks, benefits and possible side effects of MBCT have been explained to me and I have had an opportunity to ask questions. I am satisfied that I have a reasonable understanding of the therapy I will receive.

Signature _____ Date_____

Printed Name _____ Date _____

I also give consent, should she deem it necessary, for Dr. Snider to discuss my involvement in the MBCT program with my: Family physician (YES or NO) and/or my individual psychotherapist (YES or NO)

Signature _____ Date _____

Printed Name _____ Date _____