Waypoint Centre for Mental Health Care
Outpatient Services Program
TRANSITIONAL AGE YOUTH PSYCHIATRIC CONSULTATION SERVICE SELF REPORT

Date: ______________________

Name: ______________________ CB#: ____________

Date of Birth: ____________ Age: ______ Gender: ☐ Male ☐ Female

Address: ______________________

Postal Code: ____________ Phone: ____________

Email Address: ____________ Cell: ____________

Source of Income: ______________________

Drug Plan: ______________________

Pharmacy: ______________________

Parents / Step-Parents: ______________________

Partner / Spouse: ______________________

Siblings: Name: ______________________ Age: ______

Name: ______________________ Age: ______

Name: ______________________ Age: ______

Others: (includes children of your own) ______________________

Who else lives in your home?: ______________________

In your own words, please describe the main reason for this assessment: (i.e. what are your concerns)

____

____

Relevant Personal History: (please describe)

Current family relationships: ______________________

____

Relationship with extended family: ______________________

____

Is religion a part of your personal life? ______________________

____

How do you spend your leisure time? ______________________

____

Do you have any interest or involvement in hobbies, activities or sports? ____________

____

Do you enjoy video games, the internet, social networking? ☐ Yes ☐ No

How much time do you spend on these activities? ______________________

Work History: ______________________

Name: ______________________ CB#: __________

Relevant Personal History (continued): (please describe)

Education:

Currently Attending: ______________________ Grade: __________

Previously Attended: ______________________ Grades: __________

______________________ Grades: __________

______________________ Grades: __________

How old were you when you started school? ______________________

How would you describe yourself as a student? ______________________

____

Did you ever require any extra help at school? ☐ Yes ☐ No ______________________

Have you ever had to repeat a grade? ☐ Yes ☐ No If yes, what grade? __________

Did you ever have any psychological or IQ testing done? ☐ Yes ☐ No __________

If yes, please bring copies of your assessment

Have you ever been suspended or expelled from school? ☐ Yes ☐ No

If yes, please describe circumstances: ______________________

Do you have a history of skipping class? ☐ Yes ☐ No ______________________

Do you have a history of being teased or bullied? ☐ Yes ☐ No

If yes, please describe: ______________________

Do you have any involvement with the law? ______________________

____

____

Has Children's Aid Society ever been involved in your life? ☐ Yes ☐ No

If yes, please describe: ______________________

Has the use of any alcohol, street drugs, prescription drugs, gambling, sexual activity or eating disorders caused you any problems in the following areas?

☐ Health ☐ Family ☐ Marriage ☐ Work ☐ Legal

Have you ever been involved in any detox, rehab, AA/NA supports for addiction?

☐ Yes ☐ No ______________________

____

Has anyone in your family ever suffered with any of the following conditions? If so, please identify relation to you

☐ anxiety ☐ depression ☐ bipolar disorder ☐ schizophrenia ☐ ADHD

☐ learning difficulties ☐ substance use ☐ criminal history

Name: ______________________________ CB#: ______________

Developmental History:
Were you exposed to any of the following during your mother's pregnancy with you?
If so, please describe

☐ cigarettes ☐ amphetamines, cocaine ☐ marijuana ☐ alcohol
☐ other drugs (recreational or prescription): ______________________________

Are you aware of any medical problems or complications your mother endured during her pregnancy with you? ☐ Yes ☐ No ______________________________
Did you have any struggles or delays during your development? ☐ Yes ☐ No ______________

____

Sexual History:

Are you sexually active? ☐ Yes ☐ No ______________________________
What is your current method of contraception? ______________________________
Have you ever had a sexually transmitted infection? ☐ Yes ☐ No ______________
How would you describe your sexual orientation? ______________________________

For females only:

How old were you when you had your first period? ______________________________
Have you ever been pregnant? ☐ Yes ☐ No ______________________________

Have you experienced trauma or loss? ☐ Yes ☐ No
If yes, please describe: ______________________________

____

____

Do you have a history of self harm? (please describe)

____

____

____

Do you have a history of suicidal thinking / behaviours / attempts: (please describe)

____

____

Name: ______________________________ CB#: ______________

Select any of the following that are or have been a problem for you:

- ☐ depression
- ☐ anxiety / worry
- ☐ obsessions / compulsions
- ☐ avoidant behaviour
- ☐ mood swings
- ☐ elevated mood
- ☐ relationship issues
- ☐ eating disorder
- ☐ difficulties with sleeping

Please list any current medical concerns and past medical issues, surgery and/or hospitalizations:

____
____
____
____

Have you ever had: (please describe)

seizures: ☐ Yes ☐ No ______________________________

head injury: ☐ Yes ☐ No ______________________________

serious motor vehicle accident: ☐ Yes ☐ No ______________________________

serious sport related injury: ☐ Yes ☐ No ______________________________

Please list any current medications and doses you are on:

____
____
____
____

What are your strengths? ______________________________
____

What are your areas of need? ______________________________
____

Please return to TAY Consultation Service c/o Central Intake
Mailing Address: 500 Church Street, Penetanguishene, ON L9M 1G3
FAX: 705-549-1812
PHONE: 705-549-3181 Ext. 2308