Sunnybrook
HEALTH SCIENCES CENTRE

Thompson Centre Intensive Residential/Day Treatment Program - Client Information Package

Dear Client,

Welcome and thank you for considering the Frederick W. Thompson Anxiety Disorder Centre for treatment for your obsessive compulsive disorder (OCD). Our Centre specializes in the treatment of OCD and related "spectrum" disorders, including hoarding, hair pulling (trichotillomania), skin picking and body dysmorphic disorders.

The following must be submitted as part of the referral (please submit all items at once):

☐ Physician Referral Form – to be completed by the referring physician

☐ Thompson Centre Intensive Residential/Day Treatment Client Information Package– to be completed by the client

☐ Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF) – to be completed by the client

☐ Florida Obsessive Compulsive Inventory (FOCI) – to be completed by the client

Important application information

1. Please review the eligibility criteria for our program as outlined on our website.
2. All applications must be fully complete at the time of submission or it will not be reviewed.
3. Applications must be faxed or emailed to the Centre. Contact information below.
4. The client will be contacted by phone or email to confirm receipt of the application within two (2) business days from the date of submission.

Contact information for inquiries and submission:

Email: ThompsonCentreClinic@sunnybrook.ca

Fax: 416-645-0592

Phone: 416-480-4002

Website: www.sunnybrook.ca/thompson

Thank You,

The Frederick W. Thompson Anxiety Disorders Team

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Thompson Centre Intensive Residential/Day Treatment Client Information Package

This form is to be **completed by the *Client*** and submitted as part of your referral package.

CLIENT INFORMATION

Last Name: _____ First Name: _____

Gender: ❒Male ❒Female ❒Transgendered ❒Non-binary ❒Other

Address: _____ Postal Code: _____

Date of Birth (dd/mm/yyyy): _____ OHIP #: _____ Version Code: _____

Phone (Home): _____ Work: _____ Cell: _____

Best phone number to reach you at during the day: _____

Can a message be left? Yes / No With another person? Yes / No

Name: _____ Relation: _____ Phone Number: _____

Email Address: _____

Preferred Method of Communication: ❒Telephone ❒ Email

DEMOGRAPHICS	
Marital Status: ❒Single ❒Married ❒Common-Law ❒Divorced ❒Widowed	
If married or with a partner, for how long?	
Do you have children: ❒No ❒Yes If yes, please list below:	

NAME	AGE

Please fill out your physicians' contact information.

Current Psychiatrist

Name: _____ Number of years involvement? _____

Address: _____

Phone Number: _____ Postal Code: _____

Current Family Doctor

Name: _____

Address: _____

Phone Number: _____ Postal Code: _____

Please list any other current treatment providers (e.g., psychologist, therapist, social worker, case manager, etc.):

Name: _____ Role: _____ Phone: _____

Organization Name: _____

Name: _____ Role: _____ Phone: _____

Organization Name: _____

Name: _____ Role: _____ Phone: _____

Organization Name: _____

Employment History

Please check all that apply:

Are you currently: Working ❒ Full-time ❒ Part-time ❒ Casual ❒
Attending school ❒ Full-time ❒ Part-time ❒
Volunteering ❒

If you are not working or attending school, when was the last time that you did so? _____

Was your discontinuation of work/school OCD-related? If yes, please explain:

_____

_____

_____

_____

_____

Are you currently receiving any regular monthly income support? Yes ❒ No ❒

If yes, what are your sources of income? Please list below.

_____

_____

_____

_____

_____

Legal Issues

Are you currently involved with the criminal justice system (e.g. probation, parole, hearing pending, forensic treatment etc.)? ❒Yes ❒No

If yes, please explain briefly:

_____

_____

_____

_____

Other:

Will you need any special accommodations while in the program (i.e., for mobility issues, vision, hearing)?

❒Yes ❒No

If yes, please describe what these are:

_____

_____

_____

Social Habits

Do you currently use tobacco products? ❒Yes ❒No

How much? _____ How many years? _____

Do you drink alcohol? ❒Yes ❒No

If yes: How many drinks per week? _____

Do you use recreational drugs? ❒Yes ❒No

If yes: What type? _____ How often? _____

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Past Medical History

Please check all that you have been diagnosed with in the past:

❒Heart Failure ❒High Cholesterol ❒Liver Disease ❒Diabetes

❒Thyroid Problems ❒Kidney Disease ❒Heart Condition ❒Asthma

❒Stroke ❒Seizures/Epilepsy ❒Intestinal Problems

❒Reflux Disease ❒Glaucoma ❒Arthritis

❒High Blood Pressure/hypertension ❒Heart Attack/By-pass Surgery

❒Cancer: Type & Location _____

❒Other: _____

❒ Details (if said yes): _____

List any drug allergies: _____

List any food/environmental allergies: _____

Do you have anaphylaxis? ❒Yes ❒No If yes, ensure you bring at least two (2) epipens to the program.

<u>Current</u> Psychiatric Medication

Please list any medication that you are currently taking for your mental health (e.g. anxiety, depression, etc.). Include dose, duration (how long you have been on this medication), your response (any resulting change in symptoms) and your tolerance of the medication (severity of side effects).

Medication	**Reason**	**Dose**	**Duration** (weeks/months/yrs)	**Response** (much improved, minimally improved, no change, minimally worse, much worse)	**Tolerability** (side effects: none, mild, moderate, severe)
<u>Example:</u> Cipralex	OCD	20mg	1 year	Minimally improved	Mild side effects

Current Non-Psychiatric Medication

Please list any medication being taken for medical, non-psychiatric, conditions i.e. diabetes.

Medication	**Reason**	**Dose**	**Duration** (weeks/months/yrs)	**Response** (much improved, minimally improved, no change, minimally worse, much worse).

Past Psychiatric Medication

❒Not Applicable

Please list any medication that you have taken in the past for your mental health.

Medication	**Reason**	**Dose**	**Duration** (weeks/months/yrs)	**Response** (much improved, minimally improved, no change, minimally worse, much worse)	**Tolerability** (side effects: none, mild, moderate, severe)

Current and Past Psychotherapy ❒Not Applicable

Please list any current or past psychotherapy that you have received.

Type of therapy	**Group/ Individual**	**Reason**	**Frequency**	**Duration** (weeks/mths/yrs)	**Dates** (start and end)	**Response** (much improved, minimally improved, no change, minimally worse, much worse).
Example: CBT	Group	Social Anxiety	Once every 2 weeks	6 months	Jan. – June 2006	Much improved

Previous *Medical* Hospitalizations ❒ Not Applicable

Example: Head injury, concussion, broken bones, surgical procedures

Date	**Hospital**	**Reason**

Previous *Psychiatric* Hospitalizations ❒ Not Applicable

Date	**Hospital**	**Reason**

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Family Medical History
Do any serious medical conditions run in your family? (e.g. Huntington's disease, Alzheimer's etc.)

If yes, please provide details: _____

_____

Family Psychiatric History
Do you or your family members have a history of any of the following conditions?

Condition	**You**	**Relative** (mother, father, sister)	**Description**
OCD			
Hoarding Disorder			
Other OCD-related disorders (Trichotillomania/Hair-Pulling Disorder, Excoriation/Skin-Picking Disorder, Body Dysmorphic Disorder)			
Major Mood Disorders (Depression or Bipolar Affective Disorder/Manic-Depressive Illness)			
Schizophrenia or Other Psychotic Disorder			
Eating Disorder			
Anxiety Disorder (i.e. Panic Disorder, Phobia, PTSD, Social Anxiety Disorder)			
Substance Use Disorders (i.e. Alcohol, Marijuana, Other substances)			
Tourette's Disorder/Tic Disorders			
ADHD			
Suicide (history of attempts or suicide completions)			
Other Diagnosed Conditions			

Trauma History

Do you have a history of trauma (i.e. physical/sexual abuse)? ❒Yes ❒No

If yes, please describe:

Has anyone ever diagnosed you with Post-Traumatic Stress Disorder (PTSD)? ❒Yes ❒No

Have you ever engaged in self-injurious behavior (i.e. cutting, burning)? ❒Yes ❒No
If yes, please describe:

Do you currently engage in self-injurious behavior (i.e. cutting, burning)? ❒Yes ❒No
If yes, please describe:

OCD-Related Information

At what age did the obsessions or compulsions begin? _____

Describe your OCD in detail. Please describe how it interferes with your daily activities and relationships i.e., self-care (showering, getting dressed, meal-preparation); productivity (work, school); leisure (social involvement; hobbies); relationships (family, friendships).

What triggers your OCD behaviors?

Motivation for Attending the Program

Please describe why you want to come to the program (as opposed to why others may want you come):

Please describe any barriers that you feel might get in the way of your success in the program. Have you thought about what it will take to overcome those barriers?

Please add anything not covered in this questionnaire that you feel could help us understand your problem:

The following question is to be completed by a family member or someone currently living with you or close to you.

Please comment on your observations of the patient's behaviors, the ways in which you may accommodate their OCD and how their OCD affects the household.

Relationship to patient (i.e. mother, husband, brother) _____

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Name: _____ Date: _____

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)
Taking everything into consideration, during the past week how satisfied have you been with your……

	Very Poor	Poor	Fair	Good	Very Good
…..physical health?	1	2	3	4	5
…..mood?	1	2	3	4	5
…..work?	1	2	3	4	5
…..household activities?	1	2	3	4	5
…..social relationships?	1	2	3	4	5
…..family relationships?	1	2	3	4	5
…..leisure time activities?	1	2	3	4	5
…..ability to function in daily life?	1	2	3	4	5
…..sexual drive, interest and/or performance?*	1	2	3	4	5
…..economic status?	1	2	3	4	5
…..living/housing situation?*	1	2	3	4	5
…..ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
…..your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
…..overall sense of well-being?	1	2	3	4	5
…..medication? (If not taking any, check here _____ and leave item blank.)	1	2	3	4	5
…..How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.

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The Florida Obsessive Compulsive Inventory

General Instructions: The questions below are designed to help health professionals evaluate anxiety symptoms. Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder — only an evaluation by a health professional can make this determination. Answer these questions as accurately as you can.

Part A instructions
Please circle YES or NO for the following questions, based on your experience in the past MONTH:

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:			
1	Concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	YES	NO
2	Overconcern with keeping objects (clothing, tools, etc) in perfect order or arranged exactly?	YES	NO
3	Images of death or other horrible events?	YES	NO
4	Personally unacceptable religious or sexual thoughts?	YES	NO
Have you worried a lot about terrible things happening, such as:			
5	Fire, burglary or flooding of the house?	YES	NO
6	Accidentally hitting a pedestrian with your car or letting it roll down a hill?	YES	NO
7	Spreading an illness (giving someone AIDS)?	YES	NO
8	Losing something valuable?	YES	NO
9	Harm coming to a loved one because you weren't careful enough?	YES	NO
Have you worried about acting on an unwanted and senseless urge or impulse, such as:			
10	Physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests?	YES	NO
Have you felt driven to perform certain acts over and over again, such as:			
11	Excessive or ritualized washing, cleaning or grooming?	YES	NO
12	Checking light switches, water faucets, the stove, door locks or the emergency brake?	YES	NO
13	Counting, arranging; evening-up behaviors (making sure socks are at same height)?	YES	NO
14	Collecting useless objects or inspecting the garbage before it is thrown out?	YES	NO
15	Repeating routine actions (in/out of chair, going through doorway, relighting cigarette) a certain number of times or until it feels **just right**?	YES	NO
16	Needing to touch objects or people?	YES	NO
17	Unnecessary rereading or rewriting; reopening envelopes before they are mailed?	YES	NO
18	Examining your body for signs of illness?	YES	NO
19	Avoiding colors (“red” means blood), numbers (“13” is unlucky) or names (those that start with “D” signify death) that are associated with dreaded events or unpleasant thoughts?	YES	NO
20	Needing to “confess” or repeatedly asking for reassurance that you said or did something correctly?	YES	NO
If you answered YES to one or more of these questions, please continue with Part B.			

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The Florida Obsessive Compulsive Inventory (continued)

Part B instructions The following questions refer to the repeated thoughts, images, urges or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer.
Circle the most appropriate number from 0 to 4.

In the past month...					
1. On average, how much *time* is occupied by these thoughts or behaviors each day?	0 None	1 Mild (less than 1 hour)	2 Moderate (1 to 3 hours)	3 Severe (3 to 8 hours)	4 Extreme (more than 8 hours)
2. How much *distress* do they cause you?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme (disabling)
3. How hard is it for you to *control* them?	0 Complete control	1 Much control	2 Moderate control	3 Little control	4 No control
4. How much do they cause you to *avoid* doing anything, going anyplace or being with anyone?	0 No avoidance 0	1 Occasional avoidance	2 Moderate avoidance	3 Frequent and extensive avoidance	4 Extreme avoidance (house-bound)
5. How much do they *interfere* with school, work or your social or family life?	0 None	1 Slight interference	2 Definitely interferes with functioning	3 Much interference	4 Extreme interference (disabling)

For clinician use:
Sum on Part B

(Add Items 1 to 5): _____

Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder -— only an evaluation by a health professional can make this determination.