## BASIC CLIENT INFORMATION

### I. GENERAL INFORMATION

Client/Child's Name: ________________________________ Today's Date: _______________

D.O.B.:______________________________ Age: __________ Grade: _______________

School currently attending: ________________________________________________________

Email address: ________________________________________________________________

Home Address: ________________________________________ How long at this address?_______

City/Province: ________________________________ Postal Code: _____________________

Home phone #: _________________________ Other #: _____________________________

Language spoken at home: ________________Other languages spoken: ______________________

Who does the child live with: □ both parents □ mother □ father □ other (specify):_______________

Mother's Name: ______________________________________ Occupation: ______________

Telephone # to be reached at: ________________________ □ cell □ home □ work

Mother's email: ______________________________________________________________

Father's Name: ______________________________________ Occupation: ______________

Father's email: ______________________________________________________________

Telephone # to be reached at: ________________________ □ cell □ home □ work

Guardian's Name: ____________________________________ Occupation: ______________

Telephone # to be reached at: ________________________ □ cell □ home □ work

Guardian's email: _____________________________________________________________

Are biological parents of child currently: □ married □ separated □ divorced □ never married

If separated or divorced, who has *legal* custody: □ mother □father □other (specify):_______________

If separated or divorced, how do you feel your child had adjusted?

________________________________________________________________________

________________________________________________________________________

**II Reason for Referral**

Current family physician: ________________________________________ Phone: _____________________

Who referred your child for this service? ________________________________________________________

Please state your reasons for seeking help, along with what you hope to gain or accomplish from this service:

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

How long has your child had these difficulties? ___________________________________________________

Have these difficulties changed over time (e.g., become better or worse)? If so, please describe:

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Is your child currently taking any medications? ❑ Yes ❑ No
If yes, please list medications, their dose, & their uses:

_______________________________________________________________________________________

_______________________________________________________________________________________

Has your child ever received psychological counselling? ❑ Yes ❑ No
If so, by whom (professional/agency) and when: _____________________________________________

_______________________________________________________________________________________