

Contact Information Sheet

Today's Date _____

Name of parent
(if child is under 16) _____

Phone Numbers: Home _____

Work _____ (mother)
_____ (father)

Cell _____ (mother)
_____ (father)

Home Address: _____
(address & postal code)

Clients under 16 years old: Name: _____

Birthdate: _____

Name: _____

Birthdate: _____

Name: _____

Birthdate: _____

Family Doctor: Name _____

Address _____

Phone number _____

Reason for referral: (brief information about major reason for referral)

Please list any current or relevant medical history?

Have you been in therapy previously for this problem? YES NO
Did you find your previous experience with therapy to be helpful? YES NO

If not, why?

We would like permission to send your family doctor a letter to thank them for the referral.

Your initials here indicate your permission to send a letter _____.

How did you learn about our services?

(check all that apply)

- Yellow Pages___
- Family Doctor or pediatrician___ (name of doctor_____)
- Psychology Today___
- Sign in window__
- Friend/family__
- Purple Pages__
- Other_____

Insurance information

Do you have extended health care benefits? YES NO
Name of insurance company? _____

Is this a WSIB claim? YES NO
Claim number_____ worker name_____

Is this a MVA claim? YES NO
Insurance company_____

Policy number_____

Accident date _____

Worker name _____

Please answer the following questions to the best of your ability.

Pregnancy, Labor and Delivery

Health problems (if any) of mother during pregnancy with patient (i.e., bleeding, toxemia, German measles, seizures, major accidents): _____

Length of Pregnancy: _____

Any drug alcohol use? Yes or No If yes, indicate amount: _____

Did you smoke during pregnancy? Yes or No If yes, indicate amount: _____

Describe any complications of birth: _____

Baby's Weight: _____

Was the cord wrapped around the baby's neck? _____

Was mother awake when the baby was born? Yes No

Did the baby breathe spontaneously right after birth? Yes No

If no, describe difficulty _____

Any other difficulties in labor and / or delivery? _____

Age of mother at delivery _____ Age of father at delivery _____

Was there any trouble with baby's first week of life, e.g., jaundice? _____

If jaundice, did baby require phototherapy (bilirubin lights)? Yes No

Were there any problems during the first month baby was at home? _____

Medical History:

Has your child ever had a serious illness? Yes No

If so what? _____ When? _____

Has your child ever been hospitalized? Yes No

If so what? _____ When? _____

How long? _____

Has your child ever had any major operations? Yes No

If so what? _____ When? _____

Does your child have asthma or allergies? Yes No

If so what? _____

Has your child ever had a strep infection? Yes No When? _____

Has your child had any head injuries? Yes No

If so what happened? _____ When? _____

Was the child unconscious? Yes No Was the child dizzy? Yes No

Has your child had any loss of consciousness not associated with a head injury (e.g., blackout)? Yes No

Does your child have abdominal pains or vomiting? Yes No

If so, when does this occur? _____

How often does your child have headaches? _____

How are these treated? _____

Have the headaches ever been accompanied by vomiting? Yes No

Does your child have any difficulties related to eating? Yes No

If so, please describe: _____

Does your child have any difficulties related to sleeping? Yes No

If so, please describe: _____

Does your child have any difficulties related to their vision? Yes No

If so, please describe (glasses / contact lens): _____

Does your child have any difficulties related to their hearing? Yes No

If so, please describe: _____

Has there been a history of frequent ear infections? Yes No

How often? _____ When? _____

In addition to prescribed medications, record in the next set of boxes **any herbal remedies or vitamins** that your child may be taking or have used in the past.

CHILD'S MEDICATION HISTORY: (Use the back of page if needed.)	NAME OF MEDICATION:	NAME OF MEDICATION:
Prescribed by Whom?		
When Started?		
Discontinued? If so, when?		
Dosage and Time Medication Taken		
Benefits		
Side Effects		
Other Comments		
Side Effects		
Other Comments		

Motor

Age sat alone: _____ Age crawled: _____ Age walked without holding on: _____

Please rate you child's motor development compared to siblings and / or friends:

	advanced	average	slow	awkward
Running	_____	_____	_____	_____
Skipping	_____	_____	_____	_____
Climbing	_____	_____	_____	_____
Bike riding	_____	_____	_____	_____
Throwing / Catching a Ball	_____	_____	_____	_____
Self-help Skills (dressing, brushing teeth, etc.)	_____	_____	_____	_____

Please list **ALL** family member's **names** under parents. Please include step / adoptive parents. Check the names of children listed below who currently live at home and indicate if adopted or fostered.

First name of each member...	Age	Educational Level	Occupation	Health	School or behavior problems	Living with child?
Mother						
Father						

Languages spoken at home: _____

Current Family Situation:

Parents are: married separated divorced single parent widowed

Custody arrangements (if applicable): _____

Previous marriages / cohabitation _____

With which family member (s) does the child spend most time? _____

With which family member (s) does the child get along best? _____

Are there any significant conflicts between child and parent(s)? Yes No If so, what? _____

Do parents agree on how to discipline the child? Yes No

Who disciplines the child and how? _____

How does the child respond to discipline? _____

Are the child's problem(s) frequently the source of parental arguments Yes No

Are there significant marital conflicts? Yes No

Language

Age spoke first words: _____ Age used two to three words: _____

Does your child have any speech problems (stuttering, difficult to understand)? Yes No

If so, please describe: _____

Has your child ever required speech therapy? Yes No