Client Information Form

Client's Full Name: ____ **Age** ______
DOB: ______________________ **Country of Birth:** ___________________________

- ❑ **Male**
- ❑ **Female**

Contact Information:

- **Address:** ____
  ____ **Postal Code:** ___________
- **Home Phone:** ____________________ **Can a message be left? yes no**
- **Work Phone:** ____________________ **Can a message be left? yes no**
- **Mobile Phone:** ___________________ **Can a message be left? yes no**
- **Email address:** ____

Medical Information:

- **Do you have any medical concerns? yes no**
  If "yes" please provide details / diagnosis: ____
- **Are you currently receiving any medication? yes no**

  If "yes" please indicate type of medication and dosage:

  1. ____________________________________ **Dose:** ____________________
  2. ____________________________________ **Dose:** ____________________
  3. ____________________________________ **Dose:** ____________________
  4. ____________________________________ **Dose:** ____________________
  5. ____________________________________ **Dose:** ____________________

- **Do you take medication as prescribed: yes no n/a**
- **Have your ever had a significant injury / head injury? yes no**
  If yes please provide details: ____
  ____

Family Background:

Select if you have been exposed to any of the following:

- ❏ **Divorce / Separation** ____
- ❏ **Marital discomfort** ____
- ❏ **Family violence** ____
- ❏ **Death of a parent** ____
- ❏ **Death of a relative or friend** _____________________________________
- ❏ **Unemployment** ____
- ❏ **Substance abuse in the family** _____________________________________
- ❏ **Serious illness in the family** ______________________________________
- ❏ **Traumatic event** ____
- ❏ **Other** ____

Select of there is a history in your immediate or in the mother or father's extended family:

- ❏ **Autism Spectrum Disorders** — **If "Yes" who:** ______________________
- ❏ **Learning Disabilities** — **If "Yes" who:** ______________________
- ❏ **ADHD or Attention Problems** — **If "Yes" who:** ______________________
- ❏ **Depression or Bipolar Disorder** — **If "Yes" who:** ______________________
- ❏ **Behaviour Problems in School** — **If "Yes" who:** ______________________
- ❏ **Anxiety Disorders** — **If "Yes" who:** ______________________
- ❏ **Psychosis / Schizophrenia** — **If "Yes" who:** ______________________
- ❏ **Substance Abuse / Dependence** — **If "Yes" who:** ______________________
- ❏ **Other** _________________ — **If "Yes" who:** ______________________