Tania Davidson, PhD. Registered Clinical Psychologist

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Instructions: Please fill out this form as completely as possible and please print or write legibly. If you need more room to complete any section, continue writing on the back of that page. For couples and family therapy, each person should complete a set of all four pages. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with your clinician. All information is CONFIDENTIAL.

Child/Adolescent's Name (First, Middle Initial, Last)

_____

Child's Preferred Pronoun(s): _____

Parent(s): _____

Step-Parents: _____

Address_____

City/Region/Post Code_____

Phone #s: Home _____

Work_____ **Cell:** _____ **Ok to text?** _____

Email: _____ **Ok to email statements/invoices?** _____

Do you want us to use discretion when calling you or leaving messages at any of the phone #s?

No____ Yes____ (If Yes, please be specific) _____

Age_____ **Birth Date**_____ **NHI #** _____

School: _____ **Year:** _____

Parent(s):

Single____ Married____ (# years_____) Partnered____ (# years_____) Separated____ Divorced____

Widowed____ Other____ (specify)_____

Names and ages of other children_____

Significant medical problems your child has or had: _____

_____

Current Physician/GP Group: _____ **Ph#** _____

Current medications child is taking_____

If your child has had any previous mental health and/or substance abuse treatment (outpatient and inpatient), list the type and approximate start and end dates for each:

_____

_____

_____

_____

_____

If you are currently working with any other mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

_____

_____

_____

_____

SIGNATURES

Please sign in all the appropriate places:

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge. If any of the information changes I will provide updated information to your clinician as soon as possible.

_____ _____

Client Signature **Date**

I give my permission for Dr. Davidson to speak to my GP/Physician listed on the previous page and anyone else listed below to coordinate my or my child's care while undergoing psychological treatment:

_____ _____

Client / Parent Signature Date