



## UNDER 18 PSYCHOLOGICAL ASSESSMENT INTAKE

\* In order for us to provide an accurate assessment, please complete the following intake form to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your client file, it is your choice to limit that information.

Date: \_\_\_\_\_ How did you hear about our services? \_\_\_\_\_

What kind of assessment are you interested in? \_\_\_\_\_

### CLIENT INFORMATION:

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Does your child have a diagnosis or exceptionality? \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION:

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

D.O.B: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender:  M  F

Main Contact #: \_\_\_\_\_ Alternate: \_\_\_\_\_

Address:  Same as above OR \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Do you have a diagnosis or exceptionality? \_\_\_\_\_

Do you have a family history of mental or physical health concerns? \_\_\_\_\_

Married  Common-law  Separated  Divorced  Widowed -Please indicate date: \_\_\_\_\_ or  Single  
Email \* (We will use email for important correspondence): \_\_\_\_\_

**Please add me to your mail list so that I receive information about programs and services:**  Yes  No

### PARENT/GUARDIAN 2 INFORMATION:

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

D.O.B: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender:  M  F

Main Contact #: \_\_\_\_\_ Alternate: \_\_\_\_\_

Address:  Same as above OR \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Do you have a diagnosis or exceptionality? \_\_\_\_\_

Do you have a family history of mental or physical health concerns? \_\_\_\_\_

Married  Common-law  Separated  Divorced  Widowed -Please indicate date: \_\_\_\_\_ or  Single  
Email \* (We will use email for important correspondence): \_\_\_\_\_

**Please add me to your mail list so that I receive information about programs and services:**  Yes  No

**CHILD CUSTODY:** Joint  Sole  If sole, with whom? \_\_\_\_\_ (*If sole custody, we must receive court order*)

Is this child: Adopted  Foster  Other  \_\_\_\_\_ Please indicate date of adoption or placement: \_\_\_\_\_

**EMERGENCY CONTACT (other than parent):**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Main contact # (    ) \_\_\_\_\_ Alternate # (    ) \_\_\_\_\_

**Reason for Assessment:**

What is the main reason for this assessment? (please give a brief summary of the main problems)

What is hoped to achieve, improve or change? (what are your goals)

Please describe any stressors:

Is there anything else you would like us to know?

Previous/current contact with Mental Health Professionals or Support Services:

Name of Agency	Professional Involved	Type of Treatment (medication, counselling, etc.).	Date and Duration of Treatment	Was it effective?

Are you currently on any wait lists for services?

<b>Family Contacts</b>	<b>Biological</b>	<b>Step/Half</b>	<b>Adoptive</b>	<b>Foster/Guardian</b>
<b>Father</b>	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
<b>Mother</b>	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
<b>Sibling 1</b> <input type="checkbox"/> M <input type="checkbox"/> F	Name (age)	Name (age)	Name (age)	Name (age)
<b>Sibling 2</b> <input type="checkbox"/> M <input type="checkbox"/> F	Name (age)	Name (age)	Name (age)	Name (age)
<b>Sibling 3</b> <input type="checkbox"/> M <input type="checkbox"/> F	Name (age)	Name (age)	Name (age)	Name (age)
<b>Sibling 4</b> <input type="checkbox"/> M <input type="checkbox"/> F	Name (age)	Name (age)	Name (age)	Name (age)
<b>Sibling 5</b> <input type="checkbox"/> M <input type="checkbox"/> F	Name (age)	Name (age)	Name (age)	Name (age)
<b>Sibling 6</b> <input type="checkbox"/> M <input type="checkbox"/> F	Name (age)	Name (age)	Name (age)	Name (age)

Who lives in the home (names, relationship and ages)?

If child lives in more than one home please provide details on living arrangements:

## Education

Name of School/Institution:

Grade/Degree:

### School Services (Current or Previous)

- Special Education Class  IEP (Individualized Education Plan)  Resource Period  
 Educational Assistance  Tutoring  Other

## FAMILY PHYSICIAN

Name

Phone

Fax

## CHILD'S DEVELOPMENTAL HISTORY

### Prenatal Events:

Parents' attitude toward pregnancy: \_\_\_\_\_

Conception:  planned  unplanned

Pregnancy complications:(bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use etc.) \_\_\_\_\_

### Birth and Postnatal period:

Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Labor Duration: \_\_\_\_\_

Delivery:  vaginal  Cesarean Section

APGAR Scores (If Known): \_\_\_\_\_ Time In Hospital: \_\_\_\_\_

Delivery Complications? \_\_\_\_\_

Mother's Health After Delivery: \_\_\_\_\_

Post Delivery Blues?  Yes  No If Yes, How Long? \_\_\_\_\_

**Primary Caretaker For Child, First Year:** \_\_\_\_\_

Thereafter: \_\_\_\_\_

**Feeding History:** Breastfed vs Formula: \_\_\_\_\_ Age Weaned: \_\_\_\_\_

Current Eating Problems: \_\_\_\_\_

**Sleep Behavior:** Sleepwalking, nightmares, any current problems: \_\_\_\_\_

**Separations From Mother and/or Father:** Age, duration, and reaction to: \_\_\_\_\_

**Toilet Training:**(Age Reached) Bowel Control: Day \_\_\_\_\_ Night \_\_\_\_\_ Bladder Control: Day \_\_\_\_\_ Night \_\_\_\_\_

Current Problems: \_\_\_\_\_

**Sexual Development/** Gender identity: \_\_\_\_\_

Any problems: \_\_\_\_\_

**Motor Development:** (please write in age, parentheses are approximate normal limits)

Rolls over (3-5m): \_\_\_\_\_ Sit without support (5-7m): \_\_\_\_\_ Crawls (5-8) : \_\_\_\_\_

Walks well (11-16m): \_\_\_\_\_ Runs well (2y): \_\_\_\_\_ Rides tricycle (3y): \_\_\_\_\_

Throws ball overhand (4y): \_\_\_\_\_ Current level of activity: \_\_\_\_\_

Fine and gross motor coordination: \_\_\_\_\_ Compared to peers: \_\_\_\_\_

**Language Development:** (please write in age, parentheses are approximate normal limits)

Several words besides dada, mama (1y): \_\_\_\_\_ Name several objects-ball, cup (15m): \_\_\_\_\_

3 words together - subject, verb, object (24m): \_\_\_\_\_ Vocabulary: \_\_\_\_\_ Articulation: \_\_\_\_\_

Comprehension: \_\_\_\_\_ Compared to peer: \_\_\_\_\_

Any current problems: \_\_\_\_\_

**Social Development:** (please write in age, parentheses are approximate normal limits)

Smile (2m): \_\_\_\_\_ Shy with strangers (6-10m): \_\_\_\_\_ Separates from mother easily (2-3y): \_\_\_\_\_

Cooperative play with others (4y): \_\_\_\_\_

Quality of attachment to mother: \_\_\_\_\_ Quality of attachment to father: \_\_\_\_\_

Early peer interactions: \_\_\_\_\_

Current peer interactions: \_\_\_\_\_

Special interests/hobbies: \_\_\_\_\_

**Behavioral/Discipline:** compliance vs non-compliance \_\_\_\_\_

Lying/stealing: \_\_\_\_\_ Rule breaking: \_\_\_\_\_ Methods of discipline: \_\_\_\_\_

Other problems: \_\_\_\_\_

Current Personality: \_\_\_\_\_

Mood: \_\_\_\_\_ Fears/phobias: \_\_\_\_\_

Habits: \_\_\_\_\_

Ability to express feelings: \_\_\_\_\_

#### PAST HISTORY

No	Yes
----	-----

Have you been treated for your present problem or any nervous or psychiatric condition?

--	--	--

Have you ever been hospitalized for a psychiatric problem? If yes, please specify below.

**MEDICATIONS –PAST & CURRENT (INCLUDE ALL IN ORDER AND APPROX. DATES)**

Name of Drug	Dosage	# times /day	Start/End	Success:	Why Stopped?
--------------	--------	--------------	-----------	----------	--------------


**PAST MEDICAL HISTORY:**

No Yes

**1. MAJOR ILLNESSES**

--	--

Year	Illness	Treatment	Result

No Yes

**2. SURGERY**

--	--

Year	Type of Surgery	Reason for Surgery	Result

No Yes

**3. HOSPITALIZATIONS**

--	--

Year	Illness	Treatment	Result

No Yes

**4. INJURIES/ACCIDENTS**

--	--

Year	Injury

No Yes

**5. PHYSICAL/SEXUAL ABUSE**

Year	Include unreported injuries/untreated injuries (beatings/concussion/rape/abuse)	By spouse/partner/family member/other

No Yes

**6. ALLERGIES**

Drugs/Food/Environment	Type of Reaction: Allergy or Side Effect	Clarification / Allergy or Side Effect

### Review of Symptoms – Child and Adolescent

<b>For each item, place an X in the <u>most appropriate column</u></b>					
		<b>Never</b>	<b>Sometimes</b>	<b>Frequently</b>	<b>Very Frequently</b>
<b>Attention Deficit/Hyperactive Disorder</b>					
<b>Inattention</b>					
1	Fails to give close attention to details or makes careless mistakes in schoolwork or other activities				
2	Has difficulty sustaining attention in tasks or play activities				
3	Does not seem to listen when spoken to directly				
4	Does not follow through on instructions; does not complete tasks (schoolwork or chores or duties)				
5	Has difficulty organizing tasks and activities				
6	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g. homework)				
7	Loses things necessary for tasks or activities				
8	Is distracted by extraneous stimuli				
9	Is forgetful in daily activities				
<b>Hyperactivity/Impulsivity</b>					
1	Fidgets with hands/feet or squirms in seat				
2	Leaves seat in classroom or in situations in which remaining seated is expected				
3	Runs about or climbs excessively in situations in which it is inappropriate				
4	Has difficulty playing or engaging in leisure activities quietly				
5	Talks excessively				
6	Is “on the go” or acts as if “driven by a motor”				
7	Has difficulty awaiting turn in games or group situations				
8	Blurs out answers before questions have been completed				
9	Interrupts or intrudes on others, e.g. butts into other children’s games				
<b>Oppositional/Defiant</b>					
1	Loses temper				
2	Argues with adults (parents and other adults)				
3	Actively defies or refuses adult requests, expectations or rules				
4	Deliberately annoys other people				
5	Blames others for his/her mistakes or misbehaviour				
6	Is touchy or easily annoyed by others				
7	Is angry and resentful				
8	Is spiteful, vindictive, mean or hurtful toward others				
<b>Conduct problems</b>					
<b>Aggression to people and animals</b>					
1	Bullies, threatens, or intimidates others				
2	Initiates physical fights				
3	Has used a weapon that can cause serious physical harm to others (knife, gun, stick, rock, bat)				
4	Has been physically cruel to others				
5	Has been physically cruel to animals				
6	Has stolen while confronting the victim (mugging, extortion)				
7	Has forced someone into sexual activity				
<b>Destruction of property</b>					
8	Has deliberately engaged in fire-setting with the intention of causing serious damage				
9	Has destroyed or vandalizing other’s property				
<b>Deceitfulness or theft</b>					
10	Has broken into someone else’s house, building or car				
11	Lies to obtain goods or favours to avoid obligations (i.e., “cons” others)				
12	Has stolen items of non-trivial value without confronting a victim (e.g. Shoplifting, forgery)				
<b>Serious violation of rules</b>					
13	Has stayed out at night despite parental prohibitions, beginning before age 13 years				
14	Has run away from home overnight at least twice or once without returning for a lengthy period				
15	Has skipped school (truant), beginning before 13 years of age				

		<b>For each item, place an X in the most appropriate column.</b>		<b>Never</b>	<b>Sometimes</b>	<b>Frequently</b>	<b>Very Frequently</b>
<b>Tic Disorders</b>							
1	Motor tics (e.g. eye blinking, facial grimacing)	<input type="checkbox"/> Single	<input type="checkbox"/> Multiple				
2	Vocal tics (e.g. clearing throat, clicking sounds)	<input type="checkbox"/> Single	<input type="checkbox"/> Multiple				
<b>Autism Spectrum Disorder</b>							
<b>Social interaction impairment</b>							
1	Impairment in the use of non-verbal behaviours (e.g. eye-to-eye gaze, facial/body gestures)						
2	Failure to develop peer relationships appropriate to developmental level						
3	Lack of spontaneous seeking to share enjoyment, interest, or achievements with others						
4	Lack of social or emotional reciprocity						
<b>Communication impairment</b>							
5	Delay or lack of the development of spoken language						
6	Marked impairment in the ability to initiate or sustain a conversation with others (if adequate speech)						
7	Stereotyped and repetitive use of language						
8	Lack of spontaneous make-believe play or social imitative play						
<b>Restricted repetitive &amp; stereotyped patterns of behaviour, interests, &amp; activities</b>							
9	Restricted pattern of interest that is abnormal in intensity or focus						
10	Inflexible adherence to specific, non-functional routines or rituals						
11	Stereotyped or repetitive motor mannerisms (e.g., hand or finger flapping or twisting)						
12	Persistent preoccupation with parts of objects						
<b>Separation Anxiety</b>							
1	Recurrent excessive distress when separation from home/caregiver occurs/anticipated						
2	Persistent excessive worry about losing or possible harm befalling caregiver						
3	Persistent excessive worry that an untoward event will lead to separation from caregiver						
4	Persistent reluctance or refusal to go to school or elsewhere because of fear of separation						
5	Persistent excessive fear or reluctance to be alone or without caregiver at home						
6	Persistent reluctance or refusal to go to sleep without being near a caregiver or to sleep away from home						
7	Repeated nightmares involving the theme of separation						
8	Complaints of physical symptoms when separation from caregiver occurs or is anticipated						
<b>Learning Disabilities</b>							
<input type="checkbox"/> Reading		<input type="checkbox"/> Writing					
<input type="checkbox"/> Math		<input type="checkbox"/> Sequencing					
<input type="checkbox"/> Memory		<input type="checkbox"/> Organization					
<input type="checkbox"/> Abstraction		<input type="checkbox"/> Body awareness/Spatial Relationships					
<b>Communication Problems</b>							
1	Difficulties in receptive language (understanding words, sentences)						
2	Difficulties in expressive language (vocabulary, grammar)						
3	Stutters						
<b>Elimination Problems</b>							
<input type="checkbox"/> Voids into bed or clothes		<input type="checkbox"/> At least twice a week		<input type="checkbox"/> For at least 3 months			
		<input type="checkbox"/> Only during night time sleep		<input type="checkbox"/> During waking hours			
<input type="checkbox"/> Soils self		<input type="checkbox"/> At least once a month		<input type="checkbox"/> For at least 3 months			

	<b>For each item, place an X in the most appropriate column.</b>	<b>Never</b>	<b>Someti mes</b>	<b>Freque ntly</b>	<b>Very Frequen tly</b>
	<b>Depression – Over the last 2 weeks:</b>				
1	Most of the day, nearly every day, feeling: <input type="checkbox"/> sad <input type="checkbox"/> down <input type="checkbox"/> depressed <input type="checkbox"/> irritable <input type="checkbox"/> angry				
2	Losing interest or little enjoyment/pleasure in doing things or most activities				
3	Disturbance in appetite and weight: <input type="checkbox"/> poor appetite <input type="checkbox"/> overeating				
4	Disturbance in sleep: <input type="checkbox"/> trouble falling or staying asleep <input type="checkbox"/> sleeping too much				
5	Psychomotor changes: <input type="checkbox"/> slowed down; moving or speaking slowly <input type="checkbox"/> restless/fidgety: moving around a lot				
6	Feeling tired or having little energy				
7	Feeling: <input type="checkbox"/> bad about yourself <input type="checkbox"/> like a failure <input type="checkbox"/> hopeless <input type="checkbox"/> worthless				
8	<input type="checkbox"/> Diminished ability to think, focus or concentrate <input type="checkbox"/> Indecisiveness				
9	<input type="checkbox"/> Recurrent thoughts of death <input type="checkbox"/> Thinking would be better off dead				
	<input type="checkbox"/> Thinking about committing suicide <input type="checkbox"/> Actually trying to commit suicide				
	<b>High mood – for at least 1 week:</b>				
1	Most of the day, nearly every day, feeling: <input type="checkbox"/> happy <input type="checkbox"/> high <input type="checkbox"/> silly <input type="checkbox"/> irritable <input type="checkbox"/> angry				
2	Feeling unusually great about life and inflated sense of self				
3	Needing little or no sleep				
4	Talking too much or too quickly				
5	Having too many thoughts, or thoughts are racing				
6	Being too easily distracted				
7	Increased spending, risk taking, sexual interest/activity				
	<b>Anxiety</b>				
1	<b>General Anxiety:</b> <input type="checkbox"/> Excessive worry and anxiety about several events or activities, for at least 6 months <input type="checkbox"/> Trouble controlling these feelings <input type="checkbox"/> Irritable <input type="checkbox"/> Restless <input type="checkbox"/> poor Concentration <input type="checkbox"/> poor Sleep <input type="checkbox"/> low Energy <input type="checkbox"/> Tense muscles				
2	<b>Obsession:</b> Repetitive thoughts, impulses, or images that are disturbing, intrusive, and inappropriate that cases marked anxiety or distress				
3	<b>Compulsion:</b> Repetitive behaviours or mental acts that are performed in response to an obsession,(e.g., washing, checking, organizing, counting, praying ) to prevent something bad from happening				
4	<b>Social Anxiety:</b> Feeling anxious in social situations (e.g., birthday parties) and trying to avoid them				
5	<b>Panic Attack:</b> Episodes where suddenly feeling really anxious/scared: heart starts pounding, find it hard to breathe, feel dizzy, feel like going to throw up, feeling of losing control and going crazy, going to die				
6	<b>Agoraphobia:</b> Feeling anxious about being in public places (e.g., malls, stores) and trying to avoid them				
7	<b>Trauma:</b> Experienced or witnessed a traumatic event or something really bad				
8	<b>Re-experience:</b> Recurring thoughts/nightmares about something bad that has happened in the past				
9	<b>Flashback:</b> Feeling really upset when put in a situation that triggers the memories of the bad event				
10	<b>Avoidance:</b> Trying to avoid situations that can potentially bring out the memories of the bad event				
	<b>Impaired Reality</b>				
1	Hearing voices of people talking when there is no one around actually saying those things				
2	Seeing strange or scary things that no one else is able to see				
3	Having worries/fears that will be harmed by others in different ways (spying, food poisoning)				
4	Feeling that receives messages from TV, radio, or the newspaper				
5	Having disorganized thoughts and speech (incoherent)				
6	Having disorganized behaviour				
	<b>Substance Use</b> (in the past 12 months)				
1	Having 3 or more alcoholic drinks – within a 3 hour period – on 3 or more occasions				
2	Using illicit drugs more than once, to get high, to feel elated, or to get “a buzz”				
	<b>Eating Problems</b> (in the past 3 months)				
1	<b>Body Image:</b> Feeling too fat (when actually is not) and needing to lose a lot of weight to feel better				
2	<b>Restricting:</b> Trying to lose weight by eating less				
3	Severely underweight				
4	<b>Binge:</b> Episodes of eating large amounts of food and feeling eating is out of control				
5	<b>Purge:</b> Trying to lose weight by <input type="checkbox"/> exercising a lot <input type="checkbox"/> fasting <input type="checkbox"/> throwing up <input type="checkbox"/> taking pills				

M=Mother; F=Father; S=Sister, B=Brother,  
N= Niece/Nephew

<b>Family Psychiatric History</b>	No Hx				Use Sib #					Use Child #	Mother's		Father's		
		M	F	S	B	N	Aunt	Uncle	Cousin		Children	MM	MF	FM	FF
ADHD/ADD															
Aggression/Violence/Abuse															
Alcohol Abuse															
Anxiety															
Autism Spectrum Disorders															
Bipolar Disorder															
Dementia (Early/Late)															
Depression															
Drug abuse															
Eating Disorders															
Imprisonment/Detention															
Learning Disabilities															
Mental Retardation															
Obsessive Compulsive Disorder															
Oppositional Defiant Disorder															
Schizophrenia															
Suicide (Failed Attempts)															
Suicide (Successful Attempts)															
Tourette's Disorder															
Any psychiatric hospitalization															
Other:															
<b>Family Medical History</b>		No Hx	M	F	S	B	N	Aunt	Uncle	Cousin	Children	MM	MF	FM	FF
Asthma															
Cancer															
Diabetes Mellitus															
Heart Disease															
High Blood Pressure															
Irritable Bowel or Colitis															
Migraine Headaches															
Mitral Valve Prolapse															
Seizures (Epilepsy)															
Stroke															
Thyroid Disorder															
Ulcers															
Other:															
<b>Age at Death</b>															
Year of Death															
Cause of Death															
Unexpected Death															

## **INFORMED CONSENT**

Thank you for your interest in Integrate Health Services. Please be aware that all client information will be stored as confidential clinic records. Where assessment services are provided, information shared will become part of a consult letter, which will be forwarded to the client and referring physician. Any additional information shared outside the clinic would require the written permission of the client.

### **CONFIDENTIALITY:**

There are by law, certain circumstances in which confidentiality cannot be maintained.

These situations would include: (1) suspected child abuse or neglect (2) circumstances where the client has become a danger to themselves or others, (3) when information has been subpoenaed by the court. Should you have any questions about the limits of confidentiality, please contact an Integrate Health Services team member.

### **PARENTAL CONSENT:**

All children under 16 years of age require parental/guardian consent to access services at Integrate Health Services. Clients over the age of 16 (who are believed to be capable of understanding the details of informed consent) are able to sign their own consent for services.

### **APPOINTMENTS:**

Please ensure you arrive on time for your scheduled appointment, as we are unable to extend your session time. No show appointments will be subject to a full session charge.

### **INTEGRATE HEALTH SERVICES TEAM APPROACH- CIRCLE OF CARE:**

Integrate Health Services is a multi-disciplinary team working in partnership with Kids Clinic. We are comprised of various health professionals and in circumstances where it is believed to be in the best interest of the client, please be aware that personal health information may be shared among healthcare providers at Integrate Health Services and Kids Clinic. Information shared will be determined on a case-by-case basis dependent upon the needs of the individual client(s). \*When you access speech therapy services, please be aware that the information you provide to Integrate Health Services or Kids Clinic is shared with our partner Speech Therapy Centres of Canada. By signing this form, you are consenting to all services provided through Integrate Health Services or Kids Clinic, including those affiliated with Speech Therapy Centres of Canada and understand that the same limits of confidentiality apply.

### **CONFIDENTIALITY WITH CHILDREN:**

In order for children and adolescents to feel safe and be able to identify and discuss concerns, they must feel a sense of privacy and some control over the information they share. At Integrate Health Services, it is our responsibility to honour and respect the child or adolescent's confidentiality- this is crucial to developing trust and achieving positive outcomes. We understand that parent(s)/guardian(s) want to be updated regarding the assessment/counselling process and be made aware of any information that would assist them in better supporting their child/adolescent. We will always seek permission from the child / adolescent to share relevant themes or details where it is determined to be in their best interest to do so.

If other family members may participate in counselling sessions, please list them below:

Name	Relationship	Date of Birth
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**Integrate Health Services provides the following support programs and services:**

- *Psychological Assessments*
- *Counselling Services*
- *Art Therapy*
- *Applied Behaviour Analysis/Intensive Behavioural Intervention*
- *Behaviour Consultation*
- *Child/Youth/Adolescent Group Programs*
- *Parent Support and Education*
- *Education Services*
- *Occupational Therapy*
- *Speech and Language Therapy (through partnership with Speech Therapy Centres of Canada)*
- *Naturopathic Services*
- *Medical Assessment and Treatment services (by referral only through partnership with Kids Clinic)*

**CLIENT CONSENT:**

I, \_\_\_\_\_ have reviewed the above information and fully understand the details of informed consent. An Integrate Health Services team member has answered any questions I had. At this time, I make an informed choice (for myself or child) to access services at Integrate Health Services.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Signature (if over 16)

\_\_\_\_\_  
Date

If the client is under 16 years, parent/guardian consent is required (**BOTH parents in the case of a joint custody**)

\_\_\_\_\_  
Parent / Guardian Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



## APPOINTMENT CANCELLATION POLICY

1. Our policy is 24-hour (1 business day) cancellation for all scheduled appointments. For example, if your appointment is scheduled for Monday at 10 a.m., you must cancel the appointment no later than 10 a.m. the Friday before the appointment. If the appointment is on Wednesday at 2 p.m., it must be cancelled no later than Tuesday at 2 p.m.

\* Missed appointments without any prior notice may be subject to a cancellation fee up to a full session charge. **This fee cannot be billed to a third party funder or grant and must be paid directly by the client.**

2. To cancel an appointment, please call 905-683-7228.

If you cannot reach us in person or by phone, you may leave a detailed voice message with your name, date and time of your scheduled appointment and your request to cancel or reschedule.

I, \_\_\_\_\_ have reviewed and agree to the above stated policy regarding appointment cancellation.

---

Client Signature

---

Date

---

Witness Name

---

Witness Signature

---

Date

