DR. LAUREL L. JOHNSON
CLINICAL CHILD & ADOLESCENT PSYCHOLOGIST
Suite 408 - 3621 Highway 7 East
Markham, ON. L3R 0G6

Client Information

Child's Name:_____ Birthdate:_____ Age:_____

School:_____ Grade:_____

Teacher:_____

Person(s) completing this form: _____Today's Date:_____

Home Address: _____
_____
_____
_____

Phone number: _____/_____
(Home) *(Cell)*

Best number to contact you_____

E-mail: _____

Describe reasons for seeking help: _____
_____
_____
_____
_____
_____

Who suggested you contact this office? _____
_____

When was your child last examined by a physician? _____

Name of family doctor: _____ Phone:_____

List any major health problems for which your child currently receives treatment: _____
_____
_____
_____
_____
_____

List any medications your child is now taking: _____
_____
_____
_____
_____

Has your child ever received psychiatric or psychological help or counselling of any kind before?
_____

If yes, please describe: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of person(s) to be contacted in case of emergency:

_____ Phone: _____

_____ Phone: _____

_____ _____

Print Name *Signature*

_____

Date