DR. GINA MADRIGRANO
98, Centrepointe Drive, Ottawa, ON K2G 6B1
T: 613.228.1174 F: 613.228.2756 Email: dr.madrigrano@me.com

CHILD/ADOLESCENT INTAKE FORM

CHILD'S NAME : _____**DATE OF BIRTH:**_____

HOME ADDRESS: _____**CITY**:_____

POSTAL CODE: _____

PARENTS: ▢ together ▢ separated/divorced ▢ custody arrangement: _____

▢ CONSENT TO TREATMENT COMPLETED by custodial parent(s)

1) PARENT NAME: _____

ADDRESS (if different from child) _____

_____

PHONES (also check preferred mode of contact)

▢ HOME: _____

▢ CELL.: _____

▢ WORK: _____

▢ EMAIL: _____

2) OTHER PARENT NAME: _____

ADDRESS (if different from child) _____

_____

PHONES (also check preferred mode of contact)

▢ HOME: _____

▢ CELL.: _____

▢ WORK: _____

▢ EMAIL: _____

PHYSICIAN NAME: _____

INSURANCE COVERAGE ? _____

EMERGENCY CONTACT Name: _____

PHONE: _____ Relationship to child: _____

HOW DID YOU FIND ME

▢ Web search ▢ Physician (name) _____▢ Friend/Colleague

▢ Other: (specify) _____

For office use only

▢ Consent to treatment signed ▢ Intake Form ▢ Privacy policy, fees, cancellation policy, limits to confidentiality addressed (form given) ▢ Custodial parent(s) consent to tx ▢ Survey completed (specify survey: _____)