# MEMORY LANE - CLIENT INTAKE FORM 1BCLIENT 12 - 29 YEARS OF AGE

## CLIENT INFORMATION

TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 (DAY) (MONTH) (YEAR)

CLIENT’S CURRENT AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER/PRONOUNS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## CLIENT MEDICAL INFORMATION

REFFERAL FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER NECESSARY MEDICAL INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## CLIENT’S EDUCATION

CLIENT IS ENROLLED IN SCHOOL: ⃝ YES ⃝ NO

CLIENT IS ATTENDING SCHOOL: ⃝ IN PERSON ⃝ ONLINE ⃝ CHOOSES NOT TO ATTEND

CLIENT HAS AN INDIVIDUAL EDUCATION PLAN (IEP): ⃝ YES ⃝ NO

CLIENT HAS A DIAGNOSED LEARNING DISABILITY: ⃝ YES ⃝ N0

⃝ AUTISM SPECTRUM DISORDER ⃝ GENERAL LEARNING PROGRAM

⃝ BEHAVIOUR INTERVENTION PROGRAM ⃝ GIFTED PROGRAM

⃝ BLIND / LOW VISION – INTEGRATED PROGRAM ⃝ LANGUAGE LEARNING DISABILITIES PROGRAM

⃝ DEAF / HARD OF HEARING PROGRAM ⃝ LEARNING DISABILITY PROGRAM

⃝ DEVELOPMENTAL DISABILITIES PROGRAM ⃝ PHYSICAL SUPPORT PROGRAM

⃝ DUAL SUPPORT PROGRAM ⃝ PRIMARY SPECIAL NEEDS

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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CONCERNS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## CLIENT’S HISTORY

THE CLIENT IS OPEN TO NEW EXPERIENCES: ⃝ YES ⃝ NO

THE CLIENT HAS ATTENDED COUNSELLING BEFORE: ⃝YES ⃝ NO

 IF YES, WHAT WORKED AND WHAT DID NOT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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WHY DOES THE CLIENT THINK THEY ARE HERE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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WHAT ARE THE CLIENT’S SHORT AND LONG-TERM GOALS HERE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ARE THERE ANY CONCERNS SURROUNDING THE CLIENT’S DEVELOPMENT:
 ⃝ PHYSICAL ⃝ MENTAL ⃝ EMOTIONAL ⃝ SOCIAL ⃝ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THERE AN ACTIVE FILE WITH THE CHILDREN’S AID SOCIETY? ⃝ YES ⃝ NO

IS THERE AN ACTIVE FILE WITH THE OTTAWA POLICE? ⃝ YES ⃝ NO

DOES THE CLIENT EXHIBIT ANY OF THE FOLLOWING:
⃝ ADD/ADHD ⃝ AGGRESSIVE BEHAVIOUR ⃝ ANXIETY
⃝ BIPOLAR DISORDER ⃝ BULLYING BEHAVIOUR ⃝ CRYING (EXCESSIVELY)
⃝ DIFFICULTY COMMITING ⃝ DIFFICULTY CONCENTRATING ⃝ EATING DISORDERS
⃝ IMPULSE CONTROL ISSUES ⃝ INSOMNIA ⃝ LACK OF MOTIVATION
⃝ LETHARGY ⃝ LOSS OF APPETITE ⃝ NIGHTMARES
⃝ NERVOUS TICS ⃝ OBSESSIVE-COMPULSIVE ⃝ ODD BEHAVIOURS
⃝ OPPOSITIONAL DEFFIANCE ⃝ PARANOIA ⃝ PHOBIAS
⃝ PROCRASTINATION ⃝ SCHIZOPHRENIA ⃝ SEASONAL AFFECTIVE DISORDER
⃝ SUBSTANCE ABUSE ⃝ SUICIDAL TENDENCIES ⃝ TROUBLE SLEEPING

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ I CONFIRM THAT ALL PROVIDED INFORMATION IS TRUE.

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(CLIENT SIGNATURE)