INTAKE FORM

We ask that you fill in this form and return it to our main office via email: office@eatsleepandgrow.org or by fax at 587.316.5161.

Today's Date:___________________________

Child Information			
Name *(First & Last)*		DOB	
Address		Age	
		Gender	
School Name		Grade	
Resides with			
Main Language Spoken in the home			

Parent/Guardian Information					
Guardian 1			Relationship		
Email			Custody	Yes	No
Address if not Residing with Child					
Please check if it's ok to leave a message				Yes	No
Home Phone					
Cell Phone					
Work Phone					
Preferred method of communication	Home ph.	Cell ph.		Work ph.	Email
Guardian 2			Relationship		
Email			Custody	Yes	No
Address if not Residing with Child					
Please check if it's ok to leave a message				Yes	No
Home Phone					
Cell Phone					
Work Phone					
Preferred method of communication	Home ph.	Cell ph.		Work ph.	Email

Referred by:		
	Google	
	Media	
	Family Member *(please list)*	
	Friend *(please list)*	
	Other *(please explain)*	

Emergency Contact Information			
Name		Relationship	
Address			
Home Phone			
Cell Phone			
Work Phone			
Physician Contact Information			
Name			
Address			
Work Phone			

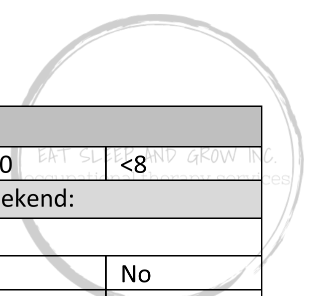
Roles/Relationship				
Family Member	Relationship	Age	Gender	Lives in Home

Medical History							
Please place a check mark by any current or past challenges							
Chicken Pox		Mumps		Pneumonia		Tonsillitis	
Bronchitis		Reflux		Allergies		Head Injury	
Ear Infections		Seizures		Measles		Asthma	
Cardiac Issues		Poor Sleep		Torticollis		Colic	

Trauma History		
Has your child ever been abused, a victim of a crime, or experienced a significant trauma?	Yes	No

Immunization/Illness						
Is your Child up to date with immunizations?					Yes	No
Please place a check mark by any services your child has accessed						
Phycologist		SLP		PT		Dietician
Psychiatrist						
Surgeries		Age		Type		
Evaluation or Testing		Age		Type *(attach documents if possible)*		

In the First two Years	
Number of earaches in the first two years	
Number of other infections in the first two years	
Number of times you had antibiotics in the first two years	



Sleep / Rest				
Average Number of hours your child sleeps at night	>12	10-12	8-10	<8
What time does your child go to bed?	Week:		Weekend:	
Does your child have difficulty falling asleep?			Yes	No
Does the child tend to wake refreshed?			Yes	No
Does your child snore?			Yes	No
Does the child wake during the night?			Yes	No

Prenatal/Birth History											
Please place a check mark beside any complications experienced during pregnancy											
Diabetes		Measles		Toxemia		Strep					
Drug Use		Alcohol Use		Pre-Eclampsia							
Please place a check mark beside any labour and delivery complications experienced											
C-Section		Vacuum		Forceps		Other					
Premature		Low Weight		IUGR		NICU Stay					
Pregnancy Duration: Please place a check mark following the week of gestation											
24	25	26	27	28	29	30	31	32	33	34	35
36	37	38	39	40 (full term)			41	42	43	44	
Easily Consoled during the first month										Yes	No
Antibiotics first month										Yes	No
Experienced no complications first month of life										Yes	No
Weight at Birth	pds	oz									
Please describe labour											

Developmental History							
Please note when each of the following occurred (months/years)							
Sat (no support)		Rolled Over		Crawled		Stood	
Walked		First Word		Spoke Clearly		Dressed Self	
Lost Eye Contact		Lost Language		Toilet Trained		Fed Self	

EAT SLEEP AND GROW INC.

Hearing and Vision				
	Yes	No		
Has your child ever had a vision test			Results	
Does your child wear glasses			Near or Far	
Has your child ever had a hearing test			Results	
Does your child where a hearing aid			Left/Right/Both	

Behaviour and Social Skills					
Please indicate if any statements describe your child					
	Yes	No		Yes	No
Follow verbal directions			Takes turn with peers		
Initiates conversation			Displays aggression		
Makes eye contact			Prefers to play alone		
Has safety awareness			Has tantrums		
Impulsive/takes risks			Extremely sensitive		
Pays attention			Unable to self-calm		
Listens well			Does not like crowds		
Plays well with others			Does well with change		

Sensory Status		
Please indicate if any statements describe your child	Yes	No
Tolerates self-care activities (bathing, tooth brushing, hair brushing)		
Appears clumsy/awkward (trips, bumps into other people or objects, trouble coordinating body)		
Has fear of using playground equipment (swinging, feet leaving ground, heights or head being upside down)		
Is constantly moving/seeks certain types of movement		
Has difficulty keeping hands to themselves (touching others or touching material objects)		
Avoids messy play/doesn't like when hands get dirty		
Appears overly sensitive to certain textures, smells, noises		
Chews on non-edible objects/puts them in mouth		
Often invades others personal space		
Is unaware of being touched or bumped unless with extreme force and does not notice when face or hands are dirty		

Immediate or Extended Family History					
Is there any known history in the immediate or extended family?					
	Yes	No		Yes	No
Autism/ PDD			ADHD		
Learning disabilities			Speech and Language Delays		
Hearing Loss			Stuttering		

Nutrition History							
Type of Formula				Soy		Cow's Milk	Low Allergy
Has your child ever had a nutrition consultation						Yes	No
Have you made any changes in your child's diet because of health problems						Yes	No
Height	ft	in	Current weight				
Does your child follow a special diet or nutrition program						Yes	No
Check all that apply							
	Dairy Free		Diabetic		Feingold		Gluten Restricted
	Gluten/Casein Free		Ketogenic		Low Oxalate		Specific Carbohydrate
	Vegan		Vegetarian		Weight Management		Wheat Free
	Yeast Free		Food Allergy (list)				
How many meals does your child eat out per week				0-1	1-3	3-5	>5
Check all the factors that apply to your child's current lifestyle and eating habits							
	Fast Eater		Most family meals together				
	Erratic Eating Pattern		Use food as a bribe or reward				
	Eat too much		Erratic meal times				
	Dislike healthy food		Most meals eaten at table				
	Time constraints		High juice intake				
	Eat more than 50% of meals away from home		Low fruit/vegetable intake				
	Poor snack choices		High sugar/sweet intake				
	Sensory issues with food		Gestational				
	Picky Eater		High blood pressure				
	Limited variety of foods (>5 per day)		High Blood				
	Prefers cold food		Have chemical exposure				
	Every meal is a struggle						
Does your child avoid any particular foods						Yes	No
If yes, types and reason							
If your child could only eat a few foods daily, what would they be?							

Are there any strategies currently in place at school to assist your child? (e.g., computer use, sitting at the front of the class, additional time to complete work, educational assistant, ect.)

Please list concerns you want to be address:

Billing and Consent			
Do you have an FSCD Contract		Yes	No
If yes, submit a copy with your application			
Caseworker Name:			
FSCD Contract Start Date		FSCD Contract End Date	

If you are paying privately, please complete the Policy/No-Show/Deposit section below	AGREE
Cancellation Fees – Cancellation or rescheduling of appointments must be done at least 24 hrs before appointment. Should you fail to show up for your scheduled appointment there will be a $50.00 No-Show charge applied to your account/credit card	
Booking Fees – We require a $50.00 deposit to secure your first initial appointment. Once you have finished your appointment your final invoice will reflect the $50.00 Booking Fee as a credit toward that appointment	
Private Clients must provide payment at the end of each session (pre-pay may be available) via e-transfer	
1 hr appointments are based on 45 min sessions with 15 min documentation/prep time or as needed	

Is there any specific day/times you would prefer an appointment or times you cannot do an appointment? We can't promise to accommodate requests, but will take them into consideration

Consent for Photos/Videos	
At Eat Sleep and Grow I find videos are very helpful in documenting a child's progress and to use for teaching purposes. I may share a photo or video with other families, or on social media to demonstrate a therapeutic strategy. As the guardian of the child, you have full right to consent or not consent to the use of this information. Please check off the applicable Agree Boxes below to indicate your preference for use of this information. (a check mark in an area will equal your initialed agreement that you are giving permission.	AGREE
I consent _ to my child being photographed or videographed for internal clinic use only. A copy will be kept on my child's file and will not be shared with anyone other than his/her therapy team	
I consent _ to my child's photo or video being used on social media to demonstrate a therapeutic strategy. I understand the photo/video will be approved by me prior to posting. My child's name will not be published	
I consent _ to my child's photo or video being used to teach other families in private sessions (i.e. no publication) My child's name will not be used	
I consent _ to my child's photo or video being used in educational presentations (e.g. PowerPoint presentations) to demonstrate a therapeutic strategy	
I DO NOT consent _ to any photo or video's being taken of my child	

I (parent/legal guardians name)	
Give permission for the child (child's name)	
To receive services from Eat Sleep and Grow Inc. The procedures, expected outcomes and consequences of intervention or of refusing intervention have been explained to me. I understand the information obtained during the assessment/consultation/s is confidential and will not be released without my informed written consent.	
Parents Signature	Date

Release Of Information Form

A listed Parent or Legal Guardian must complete and sign this form.

Today's Date ____

Child's Name ____

Child's Birthdate ____

	I authorize the release of Information to Eat Sleep and Grow Inc; Melissa Renfree from
	I authorize the release of information from Eat Sleep and Grow Inc; Melissa Renfree to:
Please list individually all sources where you authorize the release of information from or to:	

Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			

I acknowledge by my signature that I understand that although I am not required to release my information, I am giving my consent to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information that has already been released with consent and prior to my revocation.

Print Name	
Relationship to Child	
Signature	