



| A. CHILD/YOUTH INFORMATION: for Child | dren Ages : | 12 and | under | | | |
|---|------------------------------------|---------|---|---------|---------------------------|---------------------|
| Given Name(s): | | | Surname: | | | |
| Date of Birth: | | | Age: | | | |
| MM/DD/YYYY | T . | | | | | |
| Does the child/youth Identify as: Phone Nu | | | | | | |
| | ale Female Other Can we leave | | essage | | | □ No |
| Address: | | | | | PO Box #: | |
| ity: Province: | | | | | Postal Code: | |
| First Nation (if applicable): | rst Nation (if applicable): | | ous (Status) | | □ Indigenous (Non-Status) | |
| Status #: | | | | | | |
| Ontario Health Card #: | | | | Health | Card Expiry Date | 2: |
| B. FAMILY INFORMATION | | | | | | |
| 1. Given Name: | | Last Na | ame | | | |
| Relationship to Child: | | | Address: | | | ☐ Same as applicant |
| Primary Contact Number: | | | Alternative Phone Number: | | | |
| Email: | | | Contact Preference: Primary Alternative | | | |
| 2. Given Name: | | Last Na | | | □ Email | |
| 2. Given Name. | | Lastiva | aiiie | | | |
| Relationship to Child: | | Addres | ss: | | | ☐ Same as applicant |
| Primary Contact Number: | | Alterna | ative P | hone N | lumber: | |
| Email: | | Contac | t Prefe | erence: | □ Primary □ Email | □ Alternative |
| Individual resides with: Both parents Moth Other: | ner 🗆 Fa | ther | | | Number of Sibli | ings: |
| Custody Status: | | □ Fat | her | | □ Other | |
| Is the child/youth involved in any child and family s | services? | □ Yes | □ No | | | |
| Name of service: | | | | | | |
| Name of worker: | | | | | | |
| Please provide names and ages of siblings who | o reside in | or out | side tl | he hon | ne. | |
| Name | | | | | Age | |
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| Do you have a physician, nurse practitioner or specialist that you are seeing? NAME: OFFICE: PHONE NUMBER: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic. In Parent/Guardian In Physician In Agency In Other: Name: Address: Telephone: Fax: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowledge and recollection. Birth History: Did Mother have any complications during pregnancy: In Yes In No Yaginal In C-Section If yes, please describe: Fax: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowledge and recollection. Birth History: If yes, please describe: Fax: Fax: | NAME: OFFICE: PHONE NUMBER: NAME: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged Parent/Guardian Physician Agency Name: Address: Telephone: Fax: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowled and pregnare and preg | l you to come to the C □ Other: ledge and recollection ncy: □ Yes | linic. | | | |
|--|--|---|-----------|--|--|--|
| OFFICE: NAME: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic. Parent/Guardian | OFFICE: PHONE NUMBER: NAME: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged Parent/Guardian Physician Agency Name: Address: Telephone: Fax: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowledge and the set of your knowledge and your knowledge an | □ Other: dedge and recollection ncy: □ Yes | D. No | | | |
| PHONE NUMBER: NAME: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic. Parent/Guardian | PHONE NUMBER: NAME: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged and parent/Guardian | □ Other: dedge and recollection ncy: □ Yes | D. No | | | |
| NAME: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic. Parent/Guardian Physician Agency Other: | NAME: OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged Parent/Guardian Physician Agency Name: | □ Other: dedge and recollection ncy: □ Yes | D. No | | | |
| OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic. Parent/Guardian | OFFICE: PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged and a physician and a ph | □ Other: dedge and recollection ncy: □ Yes | D. No | | | |
| PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic. Parent/Guardian Physician Adgency Other: Address: Telephone: Fax: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowledge and recollection. Birth History: Did Mother have any complications during pregnancy: Yes No Vaginal (C-Section If yes, please describe: Yes No Full-Term Premature If yes, please describe: If yes, please describe: Yes No Current Weight: If yes, please describe: If yes, please describe: Yes No Current Height: If yes, please describe: Yes No Other Developmental Delay Yes No ADHD Yes No Asthma Yes No Other Diabetes Yes No Other Diabetes Yes No Other Diabetes Yes No Other Heart Condition Yes No Other G. SURGICAL HISTORY: Please list any surgeries since birth and the location of facility and date. Type of Surgery Location and Approximate Date | PHONE NUMBER: D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged and appropriate | □ Other: dedge and recollection ncy: □ Yes | D. No | | | |
| D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic. Parent/Guardian | D. REFERRAL/INFORMATION SOURCE: Please indicate who encouraged Parent/Guardian Physician Agency Name: Address: Telephone: Fax: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowled Plant Please of Your knowled Plant Please describe: Vaginal If yes, please describe: I | □ Other: dedge and recollection ncy: □ Yes | D. No | | | |
| Parent/Guardian | Parent/Guardian | □ Other: dedge and recollection ncy: □ Yes | D. No | | | |
| Name: Fax: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowledge and recollection. Birth History: Did Mother have any complications during pregnancy: Yes No Full-Term Premature Birth Weight: Any complications with baby at time of delivery: Yes No No Current Weight: If yes, please describe: F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay Yes No ADHD Yes No ASHMA Yes No Other Eczema Yes No Other Heart Condition Yes No Other G. SURGICAL HISTORY: Please list any surgeries since birth and the location of facility and date. Type of Surgery Location and Approximate Date H. MEDICATIONS: Please list any medications taken on a regular basis including natural supplements. | Name: Telephone: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowledge of of you | ledge and recollection | □ No | | | |
| Telephone: Fax: | Telephone: E. MEDICAL/BIRTH HISTORY: Please complete to the best of your known Birth History: Vaginal C-Section Full-Term Premature Birth Weight: Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay Pes No Epilepsy Asthma Pres No Other | ncy: Yes | □ No | | | |
| Birth History: Vaginal | E. MEDICAL/BIRTH HISTORY: Please complete to the best of your knowledge and yo | ncy: Yes | □ No | | | |
| Birth History: Vaginal Vaginal If yes, please describe: Vaginal Vag | Birth History: Vaginal C-Section Full-Term Premature Birth Weight: Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay Asthma Pres No ADHD Eczema Did Mother have any complications during pregnar If yes, please describe: If yes, please describe: No Current Height: Did Mother have any complications during pregnar If yes, please describe: No Developmental Delay Pres No Other | ncy: Yes | □ No | | | |
| Vaginal C-Section If yes, please describe: | □ Vaginal If yes, please describe: □ Full-Term Premature □ Premature Any complications with baby at time of delivery: Current Weight: If yes, please describe: Current Height: If yes, please describe: Current Height: If yes, please describe: Developmental Delay Yes No Epilepsy Asthma Yes No ADHD Eczema Yes No Other | | | | | |
| Vaginal C-Section If yes, please describe: | □ Vaginal If yes, please describe: □ Full-Term Premature □ Premature Any complications with baby at time of delivery: Current Weight: If yes, please describe: Current Height: If yes, please describe: Current Height: If yes, please describe: Developmental Delay Yes No Epilepsy Asthma Yes No ADHD Eczema Yes No Other | | No | | | |
| Full-Term | □ Full-Term □ Premature Birth Weight: Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay □ Yes □ No Epilepsy Asthma □ Yes □ No ADHD Eczema □ Yes □ No Other | | No | | | |
| Birth Weight: Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay | Birth Weight: Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay Any complications with baby at time of delivery: If yes, please describe: Ves on the plant of th | □ Yes □ | No | | | |
| Birth Weight: Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay | Birth Weight: Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay Yes No Eczema Any complications with baby at time of delivery: If yes, please describe: No Epilepsy Any complications with baby at time of delivery: If yes, please describe: No Epilepsy Asthma Yes No Other | □ Yes □ | No | | | |
| Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay | Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay Yes No Epilepsy Asthma Yes No Other | □ Yes □ | No | | | |
| Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay | Current Weight: Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay Yes No Epilepsy Asthma Yes No Other | □ Yes □ | No | | | |
| Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay | Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions | | | | | |
| Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay | Current Height: F. MEDICAL HISTORY: Please check boxes or list any medical conditions | | | | | |
| F. MEDICAL HISTORY: Please check boxes or list any medical conditions diagnosed since birth. Developmental Delay | F. MEDICAL HISTORY: Please check boxes or list any medical conditions Developmental Delay | | | | | |
| Developmental Delay Yes No Epilepsy Yes No Asthma Yes No ADHD Yes No No Eczema Yes No Other Diabetes Yes No Other Heart Condition Yes No Other Other Type of Surgery Location and Approximate Date Location and Approximate Date Location and Including natural supplements. | Developmental Delay | Current Height: | | | | |
| Developmental Delay Yes No Epilepsy Yes No Asthma Yes No ADHD Yes No No Eczema Yes No Other Diabetes Yes No Other Heart Condition Yes No Other Other Type of Surgery Location and Approximate Date Location and Approximate Date Location and Including natural supplements. | Developmental Delay | diganosed since hirth | | | | |
| Asthma | Asthma | diagnosed since birth | • | | | |
| Eczema | Eczema | □ Yes | □ No | | | |
| Diabetes | | □ Yes | □ No | | | |
| Heart Condition G. SURGICAL HISTORY: Please list any surgeries since birth and the location of facility and date. Type of Surgery Location and Approximate Date H. MEDICATIONS: Please list any medications taken on a regular basis including natural supplements. | Diabetes | | | | | |
| G. SURGICAL HISTORY: Please list any surgeries since birth and the location of facility and date. Type of Surgery Location and Approximate Date H. MEDICATIONS: Please list any medications taken on a regular basis including natural supplements. | | | | | | |
| Type of Surgery Location and Approximate Date H. MEDICATIONS: Please list any medications taken on a regular basis including natural supplements. | Heart Condition | | | | | |
| H. MEDICATIONS: Please list any medications taken on a regular basis including natural supplements. | , , , , , , , , , , , , , , , , , , , | | | | | |
| | Type of Surgery Locati | ion and Approximate D | ate | | | |
| | | | | | | |
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| PHARMACY: Please provide name and contact information for your current and preferred pharmacy. | H. MEDICATIONS: Please list any medications taken on a regular basis in | ncluding natural supp | lements. | | | |
| PHARMACY: Please provide name and contact information for your current and preferred pharmacy. | | | | | | |
| I. PHARMACY: Please provide name and contact information for your current and preferred pharmacy. | | | | | | |
| i. PHAKIVIACY: Please provide name and contact information for your current and preferred pharmacy. | L DUADAACV. Diamaa wax ida aa a | | - h | | | |
| Discuss Nove Address | | <u> </u> | onarmacy. | | | |
| Pharmacy Name Address Phone Fax | Phone Phone | Fax | | | | |
| Dhawara Durfamana | Dhawaay Durfayayay | | | | | |
| Pharmacy Preference: □ same as above | : | | | | | |





| J. ALLER | GIES: Please li | st any kno | own or suspe | ected allergie | es and describ | e type of read | ction. |
|------------------|------------------------|------------|----------------|----------------|------------------|----------------|-----------------------|
| Allergy to: | | Reaction: | | | | | |
| | | | | | | | |
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| | | | | | | | |
| K. VACCI | NE INFORMAT | ΓΙΟΝ: Ple | ase provide/ | attach copy | of vaccinatio | n record and/o | or list below. |
| Are all vaccines | s up to date? | | □ Yes | □ No | □ Unkno | wn | |
| Any history of | positive COVID? |) | □ Yes | □ No | □ Unkno | wn | |
| | | Va | accine | | | | Date |
| | | | | | | | |
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| | | | | | | | |
| | | | | | | | |
| | your immuniza | | | | | | |
| | OL or DAYCAR | | | ase complet | e if child is in | Daycare, Scho | 1 |
| | 'Youth's Daycar | | | | | | Grade: |
| • | ding learning o | r developr | ment: | □ Yes | □ No | | |
| If yes, please d | escribe: | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Type of Placem | nent: | | | Individual Edu | ıcation Plan (sı | necify). | |
| | r/Full-time | | | marvidadi Ede | | occiry). | |
| ☐ Not En | | | i | Educational A | ssistant | | |
| | | | | | | | |
| Other | | | I | | | | |
| Other | | | | | | | |
| M. FAMIL | Y MEDICAL HI | STORY: /s | s there a hist | tory of either | parents, or s | iblings having | any of the following. |
| CONDITION | | | NAME/AGE | of FAMILY M | EMBER | DESCRIPTION | |
| Cancer | □ Yes | □ No | | | | | |
| Diabetes | □ Yes | □ No | | | | | |
| Asthma | □ Yes | □ No | | | | | |
| Depression | □ Yes | □ No | | | | | |
| Heart Attack | □ Yes | □ No | | | | | |
| Stroke | □ Yes | □ No | | | | | |
| Other | | | | | | | |
| Other | | | | | | | |
| Other | | | | | | | |





| N. ADDITIONAL COMMENTS: | |
|---|--|
| Please use this section to add any addit | ional information you would like to share. |
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| O. PLEASE PRINT NAME, SIGN AND DATE IN BOXE | ES BELOW. |
| Completed by (PRINT NAME): | Date completed: |
| , | |
| Signature: | |
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| (A)=504.4 | LUCE CAUV |
| | L USE ONLY |
| Date Intake Received: | |
| Intake Received by: | |
| Intake Appointment Date: | |
| Intake Completion Date: | |
| Intake Completed by: | |