**DR. SHERRI BRUCE REGISTERED PSYCHOLOGIST #1458 INC.**
#39-1400 Cowichan Bay Road
Cobble Hill, BC V0R 1L3

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# Intake Form One Parent and Teen

Welcome. I want to make the most of each appointment you have with me. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is CONFIDENTIAL. If you have concerns or questions about the relevance of any information and wish to leave it blank, please do so.

Date: _____ Referral Source: _____

Adult: _____ Gender: M ____ F ____
Teen: _____ Gender: M ____ F ____
Parent Birth Date: _____ Age: ____
Teen Birth date: _____ Age: ____

Home Telephone Number: _____
Can I leave a message __, name __ and number __?

Address: _____
_____

Emergency Contact: _____ Number: _____
Relationship to client: _____

Teen's Grade: _____ School Name: _____

Family Doctor's Name & Address: _____
_____

Relevant Medical History (please describe any significant current or past medical problems): _____
_____

Past Counselling Yes No
For Whom: _____
When: _____ Where: _____
Type of Counselling: _____

Has anyone been hospitalized for a psychological difficulty? ☐ Yes ☐ No. Name of client: _____.

Type of counselling requested: Family

We give our consent to Dr. Bruce to consult with our Doctor and her professional colleagues as professional and ethically necessary
Yes No