Child's Name: ____________

Client Intake Form

*Please complete **all** sections of this form* *Once complete please fax to **905-591-2625***

Client Information

Name of Client: ______________________________
Surname First Name Middle Initial

Date of Birth: ______/________/_______ Male ☐ Female ☐
Day Month Year

Client's Address: ______________________________

City/Town: ________________ Postal Code: ________________

Languages Spoken: ________________ Interpreter Needed: Yes ☐ No ☐

Client lives with: Both Parents ☐ Mother ☐ Father ☐ Grandparent(s) ☐ Legal Guardian(s) ☐
Other:______________________________

Primary Contact

Name: ______________________________
Surname First Name Middle Initial

Address: ______________________________
If different from above
City/Town:________________ Postal Code: ________________

Home Phone: ____________ Cell Phone: ____________ Work: ____________

Relationship to Child: ☐Mother ☐Father ☐Grandparent ☐ Legal Guardian
Other:______________________________

Secondary Contact

Name: ______________________________
Surname First Name Middle Initial

Address: ______________________________
If different from above
City/Town: ________________ Postal Code: ________________

Home Phone: ____________ Cell Phone: ____________ Work: ____________

Relationship to Child: ☐Mother ☐Father ☐Grandparent ☐ Legal Guardian
Other:______________________________

Medical Information

Family Doctor: ______________________ Address: ______________________
Phone: ______________ Fax: ______________

Peadiatrician: ______________________ Address: ______________________
Phone: ______________ Fax: ______________

Neurologist: ______________________ Address: ______________________
Phone: ______________ Fax: ______________

Primary Diagnosis: ______________________________ ☐ Diagnosis Attached

Other Agencies:

Name: ______________________ ☐ Waitlisted Date: __________
Agency Name: ______________________ ☐ Discharged ☐ Involved
Phone: ______________________

Name: ______________________ ☐ Waitlisted Date: __________
Agency Name: ______________________ ☐ Discharged ☐ Involved
Phone: ______________________

Name: ______________________ ☐ Waitlisted Date: __________
Agency Name: ______________________ ☐ Discharged ☐ Involved
Phone: ______________________

Additional Information

____
____

Primary Concerns

☐ Behavior Regulation ☐ Emotional Regulation ☐ Fine Motor ☐ Gross Motor
☐ Speech & Language ☐ Self Help (Dressing) ☐ Play Skills ☐ Social Skills
☐ Self Help (Eating) ☐ Other: ______________________ ☐ Sensory

Services Requested *(Provided by Stepping Stones Child & Family Services Inc.)*

☐ Case Coordination ☐ Behavioural Intervention ☐ Respite ☐ School Support
☐ Early Intervention ☐ Child Care Consultation ☐ Advocacy ☐ Tutoring
☐ IBI/ABA Therapist ☐ Assistance to Complete Forms for Funding ☐ Training

Services Requested *(External Agencies)*

☐ Speech & Language Therapy ☐ Occupational Therapy
☐ Physiotherapy ☐ Psychological Assessment
☐ Diagnostic Developmental Assessment ☐ Specialized Nursery School
☐ Infant Development Program ☐ Dentist
☐ Doctor ______________________ ☐ Other: ______________________