Chrysalis Centre for Psychological
and Counselling Services
Suite 408, 3621 Highway 7 East
Markham, ON. L3R 0G6

Dr. Karen Ghelani, C. Psych.
Clinical Psychologist

INTAKE SHEET

A. Identifications

1. Child's name:_____ Birthdate:_____ Age:_____
School_____ Grade_____ Teacher_____
Person(s) completing this form: _____Today's date:_____

2. Mother's name:_____ Birthdate:_____
Home phone:_____ Cell Number:_____
Address: Street:_____City:_____
Postal Code:_____
Currently employed: ❑ No ❑ Yes, as:_____Work phone:_____
Email:_____

3. Father's name:_____ Birthdate:_____
Home phone:_____ Cell Number:_____
Address: Street:_____City:_____
Postal Code:_____
Currently employed: ❑ No ❑ Yes, as:_____Work phone:_____
Email:_____

4. Stepparent's name:_____ Birthdate:_____
Home phone:_____ Cell Number:_____
Address: Street:_____City:_____
Postal Code:_____
Currently employed: ❑ No ❑ Yes, as:_____Work phone:_____

5. The following next of kin can be contacted in case of an emergency:
Name:_____ Relationship_____
Home Phone:_____
Cell Number:_____Address: Street:_____
City:_____ Postal Code:_____

B. Referrals

6. Who referred you?
Name:_____ Phone Number_____

8. Family Physician
Name:_____ Phone Number_____
Location:_____
If the family physician referred you, can I send a note saying your child has started treatment/or an assessment? Yes_____ No_____
I will not release any other information at this time without your consent

Can you summarize your main concerns at this time and reason for requesting counselling/psychoeducational assessment?

_____
_____
_____
_____
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_____

Thank you

Dr. Karen Ghelani