INTEGRATE
HEALTH SERVICES

GENERAL SERVICES INTAKE - UNDER 18

Date: _____ How did you learn about our services? _____

Person completing Form: _____ What service are you interested in?: _____

CLIENT INFORMATION:

Name: _____ D.O.B _____ Age _____ Gender: ☐ M ☐ F ☐ Other

Address: _____ City: _____ Postal Code: _____

Does your child have a diagnosis or exceptionality? (if yes, please identify)_____

Does your child have any allergies?_____ Is your child taking any medication? _____

PARENT/GUARDIAN INFORMATION:

Name: _____ Relationship to Child: _____

D.O.B: _____ (Age) _____ Gender: ☐ M ☐ F ☐ Other

Main Contact #: _____ Alternate: _____

Address: ☐ Same as above OR _____ City: _____ Postal Code:_____

Do you have a diagnosis or exceptionality?_____

Do you have a family history of mental or physical health concerns? _____

☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed -Please indicate date: _____ or ☐ Single

Email * (We will use email for important correspondence):_____

***Please add me to your mail list so that I receive information about programs and services*: ☐ Yes ☐ No**

PARENT/GUARDIAN 2 INFORMATION:

Name: _____ Relationship to Child: _____

D.O.B: _____ (Age) _____ Gender: ☐ M ☐ F ☐ Other

Main Phone #: _____ Alternate: _____

Address: ☐ Same as above OR _____ City: _____ Postal Code:_____

Do you have a diagnosis or exceptionality?_____

Do you have a family history of mental health or physical concerns? _____

Marital Status:

☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed -Please indicate date: _____ or ☐ Single

Email * (We will use email for important correspondence):_____

***Please add me to your mail list so that I receive information about programs and services*: ☐ Yes ☐ No**

CHILD CUSTODY: Joint ☐ Sole ☐ If sole, with whom? _____ *(If sole custody, we must receive court order)*

Is this child: Natural ☐ Adopted ☐ Foster ☐ ____ Date of placement/adoption:_____

EMERGENCY CONTACT (other than parent):

Name: _____ Relationship to Child: _____

Main contact # ( ) _____ Alternate # ( ) _____

Previous/current contact with Mental Health Professionals or Support Services:

Name of Agency	Professional Involved	Type of Support (medication, counselling, etc.).	Date and Duration of Treatment	Was it effective?

Are you currently on any wait lists for services?: _____

_____

Family Contacts	Biological	Step/Half	Adoptive	Foster/Guardian
Parent/Guardian □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Parent/Guardian □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Sibling 1 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 2 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 3 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 4 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 5 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 6 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)

Who lives in the home (names, relationship and ages)?

If child lives in more than one home please provide details on living arrangements:

School or Daycare (Current or Previous)
Name of School: _____ School Board: _____

☐ Special Education Class ☐ IEP (Individualized Education Plan) ☐ Resource Period
☐ Educational Assistance ☐ Tutoring ☐ Other

IMPORTANT INFORMATION:
Please describe your child's strengths and interests (extracurricular activities, hobbies, things they enjoy):

What are your goals for your child/What are you hoping to achieve?

Please describe any stressors/ triggers and when your child is experiencing difficulties:

Is there anything else you would like us to know?

Please check any areas of concern that apply and provide details

☐ Delays in fine motor skills (printing, gripping items, using scissors) _____

_____

☐ Daily living/ self-care skills (dressing, toileting, hygiene, eating) _____

_____

☐ Sensory processing challenges (overly/under sensitive) _____

_____

☐ Gross motor skills (hand eye coordination, balance) _____

_____

☐ Anxiety, depression or mental health challenges _____

_____

☐ Behaviour concerns (defiance, aggression toward self/others, risk of running) _____

_____

_____

☐ School performance (attention, organization, remaining seated, academic difficulties) _____

_____

☐ Social skills (maintaining relationships, social boundaries, initiating conversation) _____

_____

☐ Communication (language delays, currently using communication tools) _____

_____

☐ Family/sibling relationships _____

☐ Regulation of emotions/irregular mood_____

☐ Developmental/Learning delays _____

INFORMED CONSENT

Thank you for your interest in Integrate Health Services. Please be aware that all client information will be stored as confidential clinic records. Where assessment services are provided, information shared will become part of a consult letter, which will be forwarded to the client and/or parent(s)/guardian(s) and referring physician. Any additional information shared outside the clinic would require the written permission of the client or parent(s)/guardian(s) (when the client is under the age of 16 or unable to provide consent).

CONFIDENTIALITY:

There are by law, certain circumstances in which confidentiality cannot be maintained.
These situations would include: (1) suspected child abuse or neglect (2) circumstances where the client has become a danger to themselves or others, (3) when information has been subpoenaed by the court. Should you have any questions about the limits of confidentiality, please contact an Integrate Health Services team member.

PARENTAL CONSENT:

All children under 16 years of age require parental/guardian consent to access services at Integrate Health Services. Clients over the age of 16 (who are believed to be capable of understanding the details of informed consent) are able to sign their own consent for services.

APPOINTMENTS:

Please ensure you arrive on time for your scheduled appointment, as we are unable to extend your session time. No show appointments will be subject to a half-session charge.

WAIVER:

My child's photograph/visual likeness may be displayed at Integrate Health Services office (for the purposes of client awards/recognition). ***I give consent*** ☐ ***I do not give consent*** ☐

INTEGRATE HEALTH SERVICES TEAM APPROACH- CIRCLE OF CARE:

Integrate Health Services is a multi-disciplinary team working in partnership with The Kids Clinic. We are comprised of various health professionals and in circumstances where it is believed to be in the best interest of the client, please be aware that personal health information may be shared among healthcare providers at Integrate Health Services and Kids Clinic. Information shared will be determined on a case-by-case basis dependant upon the needs of the individual client(s). *When you access Speech Therapy or Occupational Therapy Services, please be aware that the information you provide to Integrate Health Services is shared with our partners, Speech Therapy Centres of Canada and Ashley Rego Occupational Therapy Services. By signing this form, you are consenting to all services provided through Integrate Health Services, including those affiliated with Speech Therapy Centres of Canada and Ashley Rego Occupational Therapy Services and understand that the same limits of confidentiality apply.

CONFIDENTIALITY WITH CHILDREN:

In order for children and adolescents to feel safe and be able to identify and discuss concerns, they must feel a sense of privacy and some control over the information they share. At Integrate Health Services, it is our responsibility to honour and respect the child or adolescent's confidentiality- this is crucial to developing trust and achieving positive outcomes. We understand that parent(s)/guardian(s) want to be updated regarding the

assessment/counselling process and be made aware of any information that would assist them in better supporting their child/adolescent. We will always seek permission from the child / adolescent to share relevant themes or details where it is determined to be in their best interest to do so.

If other family members may participate in counselling sessions, please list them below:

	Name	Relationship	Date of Birth
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Integrate Health Services provides the following support programs and services:

- *Psychological Assessments*
- *Counselling Services*
- *Art Therapy*
- *Behavioural Therapy- Applied Behaviour Analysis (Comprehensive and Focused ABA)*
- *Behaviour Consultation*
- *Child/Youth/Adolescent Group Programs*
- *Parent Support and Skills Training*
- *Education Services*
- *Speech and Language Therapy (through our partnership with speech therapy centres of Canada)*
- *Occupational Therapy Services (through our partnership with Ashley Rego Occupational Therapy Services)*

CLIENT CONSENT:

I, _____ have reviewed the above information and fully understand the details of informed consent. An Integrate Health Services team member has answered any questions I had. At this time, I make an informed choice (for myself or child) to access services at Integrate Health Services. ***Please Note**: Children enrolling in a group program must have the ability to manage in a 3:1 or 4:1 ratio (dependant upon program). If you have concerns about suitability or would like to discuss options for additional support, please contact us.

_____	_____	_____
Client Name	Signature (if over 16)	Date

If the client is under 16 years, parent/guardian consent is required (***BOTH parents in the case of a joint custody***)

_____	_____	_____
Parent / Guardian Name	Signature	Date

_____	_____	_____
Parent / Guardian Name	Signature	Date

_____	_____	_____
Witness Name	Witness Signature	Date

***To be completed for client under the age of 16 prior to accessing services if parents are separated or divorced**

PARENTAL CONSENT (Custody Agreement)

Thank you for accessing services at Kids Clinic/Integrate Health Services. Please be aware that all children under the age of 16 require parental/guardian consent to access services. **In situations in which parents/guardians are separated or divorced and there is joint custody (even if the child lives only with one parent), both parents must provide signed consent before a child can access services.**

In Circumstances of Sole Custody:

I, (*parent/guardian name*)_____ being the sole custodial parent of

child's name _____, D.O.B.: _____

hereby consent to assessment or support services for this child, at Kids Clinic/Integrate Health Services.

Is there a current court order regarding custody/access for this child ☐ Yes ☐ No (this must be provided to clinic)
Does the agreement allow non-custodial parent access to information? ☐ Yes ☐ No
This custodial arrangement is: ☐ Permanent disposition ☐ Interim disposition until (date)_____

In Circumstances of Joint Custody:

I, _____ and _____
parent/guardian name *parent/guardian name*

being joint custodial parents/guardians of (*child's name)* _____,

D.O.B.: _____ hereby consent to assessment support services for this child, at Kids Clinic/Integrate Health Services.

It is my/our understanding that accessing services are intended to support my/our child's overall well-being. The purpose of accessing these services is to benefit the child involved and not to collect or gather information for court purposes. *It is parent's responsibility to advise the clinic of any changes to child custody, access to information, etc. and to provide the supporting documentation.

_____	_____	_____
Parent/Guardian Name	Signature	Date
_____	_____	_____
Parent/Guardian Name	Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

INTEGRATE
HEALTH SERVICES

APPOINTMENT CANCELLATION POLICY

1. Our policy is 24-hour (1 business day) cancellation for all scheduled appointments. For example, if your appointment is scheduled for Monday at 10 a.m., you must cancel the appointment no later than 10 a.m. the Friday before the appointment. If the appointment is on Wednesday at 2 p.m., it must be cancelled no later than Tuesday at 2 p.m.

* Missed appointments without any prior notice may be subject to a cancellation fee up to a full session charge. **This fee cannot be billed to a third party funder or grant and must be paid directly by the client.**

2. To cancel an appointment, please call 905-683-7228.

If you cannot reach us in person or by phone, you may leave a detailed voice message with your name, date and time of your scheduled appointment and your request to cancel or reschedule.

Name of Client: _____ D.O.B _____

I, _____ have reviewed and
Parent / Guardian Name

agree to the above stated policy regarding appointment cancellation.

_____ _____
Parent / Guardian Signature Date

_____ _____ _____
Witness Name Witness Signature Date