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 Trista Keating, R Psych
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 Rachel Jose, R Psych
 & Associates

ASSESSMENT AND COUNSELING

FOR ALL AGES AND PROBLEMS

ALL UNDER ONE ROOF

Adult Intake Form

Name:

Date:

Date of Birth:

Age:

Address:

Postal Code:

Phone number(s):

Email(s):

Who is your family physician?

How did you hear about us?

Briefly describe your reason for seeking help?

Please list the names of all the people residing with you:

Name	Age	Relation to you

Is there any other information which you feel would be useful to share?

Please Note: Our office requires 24 hours of notice for cancellations or rescheduling of appointments. Failure to provide adequate notice will result in a \$115 charge.