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[www.ChangeClinic.ca](http://www.ChangeClinic.ca)

**Client Information Record**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age \_\_\_\_\_

Home Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

	May we leave a message?	Preferred Contact
Home telephone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Work telephone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Mobile telephone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

**Family Physician:**

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**Contact Person: In case of emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**Referral Source:**

<input type="checkbox"/> Physician	Name: _____	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Change Clinic Website
<input type="checkbox"/> Psychiatrist	Name: _____	<input type="checkbox"/> Internet (Please specify) _____	
<input type="checkbox"/> Psychologist	Name: _____	_____	

May we have your permission to contact the person who referred you to **Change Clinic**  
 and thank them for the referral?  **Yes**       **No**