180 Bloor Street West, Suite 1204
Toronto, Ontario M5S 2V6
Tel: 416-944-9292
Fax: 416-944-3003
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:	_____	□ Yes	□ No	□
Work telephone:	_____	□ Yes	□ No	□
Mobile telephone:	_____	□ Yes	□ No	□

Family Physician:

Name:_____

Telephone:_____

Address:_____

Contact Person: In case of emergency:

Name:_____ Relationship:_____

Telephone:_____

Address:_____

Referral Source:

□ Physician Name:_____ □ Family/Friend □ Change Clinic Website
□ Psychiatrist Name:_____ □ Internet (Please specify)_____
□ 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**