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www.cmbh.space

CLIENT CONTACT FORM

(PLEASE MAKE SURE TO FILL OUT THIS FORM ENTIRELY, INDICATING N/A IF NOT APPLICABLE)

Date:	Form completed by:				
Name:	Date of Birth:		Birth:	Age:	
Gender: □Male □Female □O	ther (Describe):				
Address_					
City:	Province:			Postal Code:	
Home phone:		Cell phone:			
Work phone:		Email: _			
Preferred Contact Method: □	Home □Cell	□Work	□Email		
✓ Please circle at which nu	mber(s) it is safe	to leave a t	voicemail.		
PRIMARY PHYSICIAN					
Name:	Phone #:		Date of Last Visit:		
Address:		City:		Prov.:	
EMERGENCY CONTACT I	NFORMATIO	N			
Name:	e:Relationship to Client:				
Address:		City:		Prov.:	
Home #:		_			
*IF CHILD OR TEEN					
Legal Guardian Name:					
Relationship to client: □Parent	□Other (checl	k one. If otl	her, specify))	
Address:		City:		Prov.:	
Home #:	Cell #:	Work #:_		#:	
REFERRAL INFORMATIO	N				
Who referred you to this office	?				
If no referral, how did you find	out about these s	services?			