

200- 250 Eglinton Avenue West Toronto, ON M4R 1A7 Tel: 416-855-CMBH (2624) www.cmbh.space

## **CLIENT CONTACT FORM**

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

| Date:                           | Form comp               | leted by:      |                     |              |  |
|---------------------------------|-------------------------|----------------|---------------------|--------------|--|
| Name:                           |                         | Date of Birth: |                     | Age:         |  |
| Gender: 🗆 Male 🗆 Female         | Other (Describe):       |                |                     |              |  |
| Address                         |                         |                |                     |              |  |
| City:                           | Prov                    | Province:      |                     | Postal Code: |  |
| Home phone:                     |                         | Cell phone:    |                     |              |  |
| Work phone:                     |                         | Email: _       |                     |              |  |
| Preferred Contact Method:       | □Home □Cell             | □Work          | □Email              |              |  |
| ✓ Please circle at which        | number(s) it is safe    | to leave a v   | voicemail.          |              |  |
|                                 |                         |                |                     |              |  |
| PRIMARY PHYSICIAN               |                         |                |                     |              |  |
| Name:                           | Phone #:                |                | Date of Last Visit: |              |  |
| Address:                        |                         | _City:         |                     | Prov.:       |  |
| EMERGENCY CONTAC                | T INFORMATIO            | N              |                     |              |  |
| Name:                           | Relationship to Client: |                |                     |              |  |
| Address:                        |                         | City:          |                     | Prov.:       |  |
| Home #:                         |                         |                |                     |              |  |
| <b>*IF CHILD OR TEEN</b>        |                         |                |                     |              |  |
| Legal Guardian Name:            |                         |                |                     |              |  |
| Relationship to client: DPare   |                         |                |                     |              |  |
| Address:                        |                         | City:          |                     | Prov.:       |  |
| Home #:                         | Cell #:                 |                |                     |              |  |
| REFERRAL INFORMAT               | ION                     |                |                     |              |  |
| Who referred you to this offi   | ce?                     |                |                     |              |  |
| If no referral, how did you fit | nd out about these s    | services?      |                     |              |  |