AUBREY
PSYCHOLOGICAL SERVICES

Child's Name:_____ Date:_____

Caregiver's Name(s):_____ Sex:_____

Relationship to Child:_____ Grade:_____

Child's School:_____ Age:_____

BACKGROUND INFORMATION

How did you hear about Dr. Aubrey?_____

Please describe your present concerns: _____

_____

_____

_____

_____

Please indicate all that apply to this child:

- ☐ ADHD _____
- ☐ Anxiety _____
- ☐ Low Mood _____
- ☐ Panic Attacks _____
- ☐ Self-harm _____
- ☐ Grief _____
- ☐ Family Stress _____
- ☐ Oppositionality _____
- ☐ Aggression _____
- ☐ Other _____
- ☐ Academic Difficulties _____
- ☐ Autism _____
- ☐ Brain Injury/Concussion _____
- ☐ Tics _____
- ☐ Sleep Difficulties _____
- ☐ Feeding Issues _____
- ☐ Eating Disorder _____
- ☐ Soiling/Bedwetting_____
- ☐ Adjustment to Medical Condition(s) _____
- ☐ Other _____

Please list any medications your child currently takes:_____

Who is your child's family doctor and/or pediatrician?_____

Does this child have any medical issues? If so please list:_____

Has this child seen a psychologist or counsellor before? Yes No _____

Do you have extended healthcare benefits? Yes No _____