Mental Health & Autism Services

MAJESTIC MINDS

CLIENTS NAME:

DATE OF BIRTH:

PRIMARY DIAGNOSIS:

OTHER SERVICES:

START DATE:

IMMEDIATE INFORMATION:

SIGNIFICANT ALLERGIES:

EMERGENCY PHONE NUMBER & NAME:

FATHER'S NAME: FATHERS #

FATHERS EMAIL: WORK #

MOTHER'S NAME: MOTHERS #

MOTHERS EMAIL: WORK #

ADDRESS:

THE FOLLOWING INDIVIDUALS THAT ARE APPROVED TO PICK UP CLIENT FROM PROGRAM:

NAME: RELATIONSHIP:

PHONE NUMBER:

PRIMARY INFORMATION:

LANGUAGES IN HOME:

SIBLINGS:

CHILD'S PRIMARY PHYSICIAN:

MEDICAL SPECIALISTS:

MEDICATION:

SEIZURES: Y - N

SPECIALIZED DIETS OR MEDICATIONS: Y - N

REQUESTED TO ADMINISTER MEDICATIONS: Y - N

IF YES, SPECIFY:

STRENGTHS:

-
-
-
-
-
-

AREAS OF DIFFICULTY:

-
-
-
-
-

CURRENT SCHOOL PERFORMANCES: (LEVELS OF ATTENTION/FOCUS, SPECIAL ARRANGEMENTS ETC):

CURRENT SOCIAL PERFORMANCE:

SHORT TERM GOAL:

LONG-TERM GOAL:

BEHAVIOURS:

INTERESTS:

ADDITIONAL INFORMATION:

CONTACT INFORMATION:

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