

ADOPTION SUPPORT GROUP : INTAKE FORM

PERSONAL INFORMATION

Mother's Name: _____ **Age:** ____
Mother's Address: _____
Occupation: _____

*Indicate if messages may be left at this number

Mother's Phone:(H) _____
Mother's Phone: (W) _____
Mother's Email: _____

Father's Name: _____ **Age:** ____
Father's Address: _____
Occupation: _____

*Indicate if message may be left at this number

Father's Phone:(H) _____
Father's Phone: (W) _____
Father's Email: _____

FAMILY INFORMATION

Child's Name: _____
Date of Birth: _____ **Age:** ____
Status: **Adopted** **Biological** **Age at Adoption:** _____
Child's Address: _____

Child's Name: _____
Date of Birth: _____ **Age:** ____
Status: **Adopted** **Biological** **Age at Adoption:** _____
Child's Address: _____

OTHERS LIVING IN THE HOME

Name: _____ Age _____

Relationship: _____ Age _____

Name: _____ Age _____

Relationship: _____ Age _____

Name: _____ Age _____

Relationship: _____ Age _____

REFERRAL

Referral Source: _____

Reason for Referral:

Please Fax completed forms to
Annette Kussin, Leaside Therapy Centre, Fax: 416-440-4019
1395 Bayview Avenue, Toronto, Ontario M4G3A6

OFFICE USE ONLY

Client No. _____

Date Opened: _____

Date Closed: _____

Service Completed: _____

Billing Address:

