Bedbugs (the last 12 months): Yes ☐ No ☐ Date: ____ / ____ / ____
Day Month Year

Female ☐ Male ☐ Other ☐

Last name: _____ First: _____

Birthdate: ____ / ____ / ____ Age: _____
Day Month Year

Address: _____ / _____
Apt # Civic Number Street City Postal Code

Tel: _____ Cell: _____

Email: _____

Emergency contact: _____ Tel: _____

Relationship: _____

Language: French ☐ English ☐ Other: _____

Civil status: Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widow(er) ☐

Number of children: _____

Currently living in: Apartment ☐ House ☐ Room ☐ Family ☐ Shelter ☐

Hospital ☐ Supervised apt. ☐ Coop ☐ Other: _____

Source of income: Employment ☐ Pension ☐ Unemployment ☐ Welfare ☐

Disability ☐ Other: _____

Have you used our services before? Yes ☐ No☐ When? _____

Referred by: _____ Tel: _____

Relationship: _____

Diagnosis and/or psychiatric history:

Reason for referral:

Client's objectives:

Comments or significant elements concerning referred client:

Other resources:

Psychiatrist / Psychologist:

Family doctor: Dr.

You or your client consents to meeting with a community worker: Yes ☐ No ☐

I authorize Perspective Communautaire en Santé Mentale to share personal information with my intervening parties, for a 90 day period.

Client's signature: Date: ____ / ____ / ____
Day Month Year