

Personal Details

The following information will be retained on our records and only used in matters relating to the treatment of the child. All information is held in strict confidence and is not shared with any other organization or professional without the consent of the parent or legal guardian of the child.

Please fill out all sections

Child's Full Name: _____ Male / Female (Please Circle)

Male Guardian's or Father's Full Name: _____

Female Guardian's or Mother's Full Name: _____

If Parents are Separated Please Indicate (✓):

Phone Number (H) _____ (W) _____ (M) _____

Postal Address: (No. and Street or PO Box) _____

Suburb/Town/City: _____ Post Code: _____

How far from the CDN does the child live (or go to school) in Travel Time _____

E-Mail Address: _____

School: _____

Date of Birth: _____ Year of Schooling: _____ Age in Years: _____ Months: _____

Is the child left or right handed? _____

Female Guardian's or Mother's Occupation: _____

Male Guardian's or Father's Occupation: _____

Number of children in family: _____ Child's Position in Family: _____

Name and Address of General Practitioner: _____

Name of Referring Practitioner: _____

Thank-you for your co-operation in filling out this form