ONE CARE INC.
32 Elgin St. East
Oshawa, ON
L1G 1T1
416-454-9340
905-240-2203

Date:_____

CLINIC REGISTRATION

Client Information:
First Name:
Last Name:
Date of Birth:
Summary of Exceptionalities: (i.e. Autism Spectrum Disorder (ASD), Learning Disability (LD), Attention Deficit Disorder (ADD):
Date of Diagnosis:
Diagnosing Clinician(s):

Have there been any past interventions completed? (For example: Occupational therapy, Speech Therapy, Music Therapy, Social Programs, etc? Please include details on dates and providers.

Parent/Guardian Information:	
PARENT 1:	**PARENT 2:**
Fist Name:	**First Name:**
Last Name:	**Last Name:**
Address:	**Address:**
Home Phone:	**Home Phone:**
Cell Phone:	**Cell Phone:**
Email:	**Email:**
Sibling:	**Age:**
Sibling:	**Age:**
Sibling:	**Age:**
Custody Information: **Child is living with: Both parents ☐ Mother ☐ Father ☐ Other ☐**	
Custody: Both parents ☐ Joint ☐ Exclusive ☐ Crown ☐ **Special Arrangements _____**	

your child:
Please specify any special custody or access arrangements that pertain to the child and provide supporting documentation:

More About Your Child:
1. **Family Physician/Pediatrician:**
2. **Does your son/daughter take any prescribed medicines? IF so please list**
3. **Any medical concerns? /Allergies?**
4. **Is your son/daughter Immunized? If so, please provide proof of immunization with contract provided. If your child is not immunized and there is an outbreak or suspected outbreak of any communicable illness, services may be suspended.**
5. **Is your son /daughter on a special diet?**
6. **Is your son/daughter toilet trained? If not, please provide details.**

School Information (if applicable):
School Name:
Grade:
Teacher:
Phone Number:

Psychological Education Assessment completed?
Level of support?
IPRC complete? Date of identification?
Individual Education Plan complete? (IEP)
Other Professionals: (involved with your son/daughter)? Ie. Speech therapy, Occupational Therapy etc. Please note: A separate exchange of information form will be required before any contact between One Care Inc. and other professionals is initiated. The information below is solely to track contact information and current interventions.
Name:
Role:
Email:
Phone Number:
Name:
Role:
Email:
Phone Number:

Program Information:
1. **What are your primary goals for ABA?**

2. **What is your son/daughter's strengths?**

3. **What do you consider to be your son/daughter's areas of need?**

4. **How does your son/daughter indicate if they are frustrated or anxious?**

5. **Does your child react to any specific sensory stimulation (e.g. loud noises)? If so, what does that look like?**

6. **What toys/activities does your son/daughter enjoy to do? What is his/her best motivators?**

7. **How do you re-direct/guide your son/daughter?**
   (For example: How do you help them through difficult behaviours? What does this typically look like for you?

Preferred Session Times:					
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Other**

For internal use only:

REFERAL SOURCE:

Funding:

- ☐ Private
- ☐ Insurance _____
- ☐ Government _____
- ☐ Other _____