DR. DOUGLAS MASKALL INC.
CHILD AND ADOLESCENT PSYCHIATRY
15521 Russell Avenue, White Rock, B.C., V4B 2R4
Telephone: (604) 541-7171
Fax: (604) 538-8500

PATIENT NAME:____**Birthdate**_______/____/______
Month Day Year

Address____

City ______________________________________ **Postal Code**__________________

Home Phone(s):	Parent Work Phone(s):	Cell Phone(s):

Present School ____**Grade**__________

LIVES WITH *(please list below, if more space needed please write on back of sheet)*:

NAME	AGE *(if child or youth)*	**Relationship***(eg sister, brother, parent)*	Occupation (if employed)

Who is/are the legal guardian(s)? ____

Address and phone number (if different from above):

____

____

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Briefly summarize main concerns:

What assessments or treatment has previously been sought for these concerns?:

Any medical conditions?: Yes ____ No ____ (if Yes, please summarize below)

Current Medications (list):

Allergies:

Family history of psychiatric illness?: Yes ____ No ____ (if Yes, please summarize below)