



Headquarters:
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1 866 821 0777
 Patient needs help with video set up:
 Y N

Independent Living Patient Intake

Patient Information:

Patient's Name: _____ DOB: _____ Gender: _____
MM/DD/YYYY

Patient's Address: _____

Phone: _____

Name of Residence: _____ Unit #: _____

E-mail: _____

Health Card #: _____ Health Card Expiry: _____
MM/DD/YYYY

Do you have an open Motor Vehicle Accident Claim? Y N

Have you ever used Cannabis? Y N

Are you a veteran? Y N If Yes, what is your K# _____

Have you been diagnosed with:

- Bipolar 1
- Bipolar 2
- Schizophrenia
- Psychosis

Please advise your appointment time preference:

- Daytime
- Evening
- Weekends

Patient Signature: _____ Date: _____
MM/DD/YYYY