Center for Anxiety & Social Intervention

Evidence-based psychotherapy and assessment
for children, teens, and families

CLIENT INTAKE FORM

Name *(Last, First, M.I.):*		☐ M ☐ F **DOB:**	
Street Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Best Phone Number to leave a confidential message?**		
Employer's Name, Address, and Work Phone			
Primary Care Physician		**Phone:**	**Notify of your visit?** ☐ Yes ☐ No
How did you hear about us?			

IN CASE OF EMERGENCY

Name *(Last, First, M.I.):*			**Relationship to You**
Street Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		

Brief Health History

Previous mental health treatment/therapy (including psychiatric hospitalizations, outpatient therapy, biofeedback, etc.):

Type of Treatment	Location (Clinic, hospital, day treatment facility, residential)	Length of Treatment	Name of treating professional

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Medication Name	Dosage & Frequency	Prescribing Physician (if applicable)