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 message about client?**		
How did you hear about us?			

PARENT'S INFORMATION (PRIMARY CONTACT PERSON)			
Name *(Last, First, M.I.):*			**DOB:**
Street Address:	**City:**	**State:**	**Zip:**
Best Phone Number:	**E-mail Address:**		
Employer's Name, Address, and Work Phone			
ADDITIONAL PARENT'S INFORMATION (OR ADDITIONAL CONTACT PERSON)			
Name *(Last, First, M.I.):*			**DOB:**
Street Address:	**City:**	**State:**	**Zip:**
Best Phone Number:	**E-mail Address:**		
Employer's Name, Address, and Work 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 child's prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Medication Name	Dosage & Frequency	Prescribing Physician (if applicable)	