

Initial Intake Form

Date of Referral:

Referral Resource:

Client Name:

DOB:

Parent Name (when applicable):

Home Address:

Home Phone:

Cell:

Email:

Parent Name:

Sibling Name:

Sibling Name:

Presenting Problem:

Other Family Members and Relationship to Client:

Other Professionals Involved with the Client:

Goals:

First Appointment Time:

Comments:

Visa Information: If you would like to pay by Visa or Mastercard, we will bill your visa weekly. A cancellation of your appointment needs to be made within 48-hours of appointment time (depending on nature of cancellation), otherwise your visa will be charged for the appointment. Your appointment time is reserved just for you and thus when you commit to a time the session is not open or available to other clients. Please be aware of the cancellation policy.

Card No.:

Card Date: