

ANXIETY & AGORAPHOBIA TREATMENT CENTER, LTD.

Specializing In Anxiety & Stress Related Disorders

— INTAKE INFORMATION FORM —

PATIENT

Name: _____ Date of Evaluation: _____

Gender: _____ Date of Birth: _____ Age: _____ Race/Ethnicity: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

Occupation: _____ Work Phone: _____

Email: _____

Current Diagnoses: _____

Current Medications: _____

Current Psychiatrist: _____

Psychiatrist Phone: _____ Psychiatrist Fax: _____

Referred by: _____ Phone: _____ Fax: _____

Child Patients Only:

Mother's Information:

Name: _____ Occupation: _____

Age: _____ Education Level: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Other Info: _____

Father's Information:

Name: _____ Occupation: _____

Age: _____ Education Level: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Other Info: _____