CENTER FOR ATTACHMENT & TRAUMA SERVICES, INC.

INTAKE FORM (for all clients)

Client Name: _____ Date of Birth: _____

Sex:_____ Highest Grade Level Achieved: _____ Occupation:_____

Address: _____

_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Person/Agency Responsible for Payment: _____

Intake/Interview Date: _____ Intake Therapist: _____

Reason for Requesting Services: _____

_____

_____

Diagnosis: _____

Medicine: _____

_____

Referral Source: _____phone:_____

Other Providers: _____

Family Information:

Name	Age	Relationship	Occupation/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Additional names continued on back of form)

Summary of intake session (observations, interventions, rec's for additional services, referrals made)

_____

_____

Treatment Goals:

1._____

2._____

3._____

Revised Treatment Goals: _____

_____

_____