Academic & Behavioral Assessment Center

Tel: 617-427-0829 **Fax:** 617-427-7804

INTAKE FORM

Date:____________ M.I.S.#:___________

Client Name:_______________________________________ D.O.B.:___________

Address:_________________________________ City:__________________________

SS#________________________ Phone: ( )___________________

Other Phone ( )_________________

Race/Ethnicity:_________________ Gender: (1) Female __ (2) Male__

Parent/Guardian if Child:____

Name/ Address/Phone if different from client: ______________________________________

Referred by:____

Of: (agency affiliation):__________________________________Phone:______________

Reason for Referral: ____

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Type of Service/s Requested:

____

Source of Payment:

- ☐ Self
- ☐ Insurance:name/number____
  Subscriber:_______________________________

A.B.A.C. Clinician Assigned (ABAC Staff only):____________________________________

Date of first appt:___________________________

Notes (ABAC Staff only):

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