THE CENTER FOR
COGNITIVE THERAPY

CONFIDENTIAL CLIENT INFORMATION

Today's Date: _____ Referred By: _____

Child's Name: _____ Date of Birth: _____

Child Age: _____ Grade: _____ School: _____

Address: _____

_____

_____

Parent/Guardian Information

Parent/Guardian's Marital Status: _____

Parent/Guardian's Name (1) _____

Primary Phone: _____ Secondary Phone: _____

*Email: _____

***Email is not a 100% secure form of communication. Please initial if you consent to contact by email:** _____

Address (if different from child's) _____

_____

Parent/Guardian's Name (2) _____

Primary Phone: _____ Secondary Phone: _____

*Email: _____

***Email is not a 100% secure form of communication. Please initial if okay to contact by email: _____**

Address (if different from child's) _____

_____

Pediatrician Information

Pediatrician: _____

Address: _____