Therapy Associates of Boca Raton

2900 North Military Trail, Suite 165

Boca Raton, Florida 33431

(561) 241-4311

Client Intake Form

Name: _____ **D.O.B.**_____

Name of Parent or Guardian: (if under age 18) _____

Address: _____

City: _____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell:**_____

Work: _____ **e-mail:** _____

(Please indicate where you prefer to be contacted/or leave a message)

Employer/School:_____

Marital Status:_____ **Spouse's name:**_____

Children's Names and Ages: _____

Primary Care Physician: _____ **Phone:** _____

Psychiatrist (if applicable)**:**_____ **Phone:**_____

Referral Source: _____ **Phone:** _____

Insurance Company: _____

Name of Insured: _____**S.S.#** _____

Member ID#: _____**Phone:** _____

Secondary Insurance (if applicable)**:**_____

(I understand and agree that I am responsible for my account balances for professional services rendered, regardless of my

insurance status. All information provided is true and correct, to the best of my knowledge.

Client Intake Form (cont.)

Please describe reasons for seeking treatment at this time: _____

_____

_____

Have you previously received any type of psychological/psychiatric treatment_____

_____

Current Medications and Dosages (if applicable)**: _____**

_____

Prior Medications:_____

Current Physical Health and Medications: _____

_____

Please indicate any information about you that will be pertinent in helping you at this time

(Including any family psychological/medical history)**:_____**

_____

_____

Please briefly state your goals for therapy: _____

_____

_____

_____ _____

Patient (parent) signature **Date**