112 Lake Street, Burlington VT
Fax: 802-859-3309

CHILD & ADOLESCENT INTAKE FORM

Please note: Missing information may delay the referral process.

Date:_____________

Last Name: ____________________________________ First Name: _____________________________________

Sex: M/F Current Age:_______ DOB:________________ School__________________________ Grade___________

Parents/Guardians: Married Separated Divorced Unmarried

Legal Responsibility: _______________________________________ Pediatrician: ____________________________

Mother:_______________________________________ Father:____
Natural Adoptive Foster Step Natural Adoptive Foster Step

Address:_____________________________________ Address:____

_____________________________________ ____

Tel. (H)______________________________________ (H)____

(W)______________________________________ (W)____

(C)______________________________________ (C)____

Email:____

To Make an Appt. Contact: _____________________________ Telephone: __________________________________

Referred By: ____ Role:_______________________________________

Current Medication: ____

Current Diagnosis (if applicable): ____

Reason for Referral (be specific):____

INSURANCE/BILLING INFORMATION

Insurance:____ Tele: ____

Policy ID#: _______________________________________ GRP#: _______________________________________

Employer: ____

Subscriber: _______________________________________ SSN: ____

Please fax to Vermont Center for Anxiety Care @ 802-859-3309. Thank you.