THE CENTER FOR
COGNITIVE
THERAPY

CONFIDENTIAL CLIENT INFORMATION

Child Information:

Today's Date: ________________________

Referred By: _________________________

Child's Name: _______________________

Date of Birth: _______________________

Home Address: ____

City/State/Zip: ____

Parent/Guardian Information:

Parent/Guardian's Marital Status: S M D W

Parent/Guardian's Name: _____________________________

Work Phone: _______________________________________

Home Phone: _______________________________________

Cell Phone: ____

Address (if different from child's): _________________________________

Email Address: ____*

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

____

Parent/Guardian's Name: _____________________________

Work Phone: _______________________________________

Home Phone: _______________________________________

Cell Phone: ____

Address (if different from child's): _________________________________

Email Address: ____*

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

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OFFICE (703) 618-0900

300 North Washington Street | Suite 304
Falls Church, VA 22046

centerforcbtva.com

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Pediatrician Information

Pediatrician:____ Address:__

Permission to contact your pediatrician? _________yes ______ no

Permission to contact the referral source? _________yes ______ no

I give consent for my child to receive assessment/psychotherapy

____ ____________
Signature of Parent Date

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