The Center for ADHD, Inc. Intake Form

Date:
Name of patient:
Patient's date of birth: Phone no
Patient/family email address
Brief reason for evaluation:
Prior psychiatric treatment, medications and outcomes (incl. hospitalizations):
Past medical history and current medications being taken:
Referred by:
Insurance name and policy number:
Phone no. for mental health benefits:
Name of insured:
Date of birth: Insured phone no
Social security no. (if it is policy no.):

Please return to centerforadhd@bellsouth.net or fax to (985)624-8643