UNIVERSITY OF CENTRAL ARKANSAS

DEPARTMENT OF PSYCHOLOGY AND COUNSELING

University of Central Arkansas
Psychology and Counseling Clinic

Intake Form

Client's Name _____
First Middle Last

Address _____
Number and Street Address

_____
City and State

Date of Birth _____ Age _____ Sex _____
Month/day/year

Home phone _____ cell phone _____

e-mail address _____

Schools Attended (beginning with 7th grade; please bring most current transcript)

_____

_____

_____

_____

_____

List any special programs you attended while in school

Type of Program Name of School Dates Attended

_____

_____

_____

_____

Father's Name _____Occupation _____

Business and Address _____

Phone (home) _____ cell _____

Highest Level of Education _____

E-mail address _____

Mother's Name _____ Occupation _____

Business and Address_____

Phone (home) _____ cell _____

Highest Level of Education _____

E-mail _____

Guardian (if other than parent) _____

Guardian's Address _____

Guardian's Phone _____
Cell _____
E-mail _____

Siblings

Age	School Grade/ College Level	Specify Any Learning Problems

Reason for Testing Referral

ACT scores: EN ____ MA ____ RD ____ SR___ Composite Score ____

Date of test _____

SAT scores: Math _____ Verbal _____ Date of test _____

Previous Assessment History (Please include the Clinician seen and date of assessment)

Please bring a copy of the most recent assessment.