Date: ______________________ Referred by: ___________________________________

Arrows Behavior Therapy & Consulting - Initial Contact Form

Child: ____ **Date of Birth:** _____/_____/_________
Address:____
City______________________________________ **State**___________________ **Zip**_____________

Mother: ____ Phone: ___________________________
e-mail: ____
Father: ____ Phone:___________________________
e-mail: ____

Preferred Method of Communication: ___ Call ___ Text ___ Email

Primary Insurance: ____
ID#: ____ Group #: _________________________
Secondary Insurance: ____
ID#: ____ Group #: _________________________

Diagnosis:
Date: __________________ Diagnosed by: ____

Previous Treatment provider and dates of service:____

Primary Care Physician:
Name: ____
Phone: _______________________________________ Fax: __________________________________

Education:
Current School: ____Grade: ______________
Services provided through school:____

Availability:
In-Home/ Days and hours: ____
In-School: _____________________________________ In-Clinic:______________________________

Email: intake@arrowsaba.com Fax: 870-292-3580