

CLIENT INTAKE FORM
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Date: _____

First Name: _____ Last Name: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ May I call and/or leave a message? _____

Additional Phone: () _____ May I call and/or leave a message? _____

Email: _____ May I contact you via email? _____

Date of Birth: ____/____/____ Age: _____

How do you describe your racial/ethnic group?: _____

Occupation: _____

If you are under the care of a physician, please indicate why:

Please list any medications you are taking that may affect your mood or behavior:

Person to contact in case of emergency:

Name: _____

Phone: () _____

What is this person's relation to you? _____