

**Claire Dumke, Psy.D.**  
Licensed Clinical Psychologist  
4155 E. Jewell Ave Suite 805, Denver CO 80222  
Phone: 720.238.7383  
Fax: 303.935.5085  
Email: cdumke@autismdiagnostic.com

---

**CLIENT INFORMATION**

Name of Client: \_\_\_\_\_ Date of Intake: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #s: \_\_\_\_\_

**Parent Information:**

Mother's Name & Address: _____ _____ Phone #s: _____ E-Mail Address: _____ Occupation: _____ Parents' Marital Status: (Circle One) Single                      Married	Father's Name & Address: _____ _____ Phone #s: _____ E-Mail Address: _____ Occupation: _____ Divorced                      Widowed
---	--

---

**Emergency Contact:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**School Information:**

School District: \_\_\_\_\_  
Name of School & Address:  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Teacher: \_\_\_\_\_  
Grade: \_\_\_\_\_  
Length of Employment: \_\_\_\_\_

---

**Pediatrician/ Doctor:**

Name of Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Neurologist:**

Name of Neurologist: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

---

**Psychologist/Psychiatrist:**

Name of Psychologist/Psychiatrist: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Other Service Provider:**

Type of Service: \_\_\_\_\_  
Name of Service Provider & Address:  
\_\_\_\_\_  
Phone: \_\_\_\_\_