

☆  
Anxiety Treatment  
Center of Austin

**Patient Demographics**

Please provide us with the following background and contact information.

**First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Name you prefer to be called:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Birth Sex:** ☐ Male ☐ Female ☐ Unknown

**Gender Identity:** Choose an item.

**Sexual Orientation:** Choose an item.

**Race:** Choose an item.

**Relationship Status:** ☐ Married ☐ Single ☐ Other: \_\_\_\_\_

**Employment Status:** ☐ Employed ☐ Unemployed ☐ F/T Student ☐ P/T Student

**Home Address:** \_\_\_\_\_

\_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**City/State:** \_\_\_\_\_

**Preferred Phone Number:** \_\_\_\_\_ ☐ Mobile ☐ Home ☐ Work

**May we:** ☐ Leave a voicemail? ☐ Send a text message?

**Secondary Phone Number:** \_\_\_\_\_ ☐ Mobile ☐ Home ☐ Work

**May we:** ☐ Leave a voicemail? ☐ Send a text message?

**Email Address:** \_\_\_\_\_

**May we:** ☐ Send an email?

**How did you hear about us?** \_\_\_\_\_