



NORTHWEST COUNSEL
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Client Intake Form

Today's Date _____

Name (last, first) _____

Address _____ City _____ State _____ Zip _____

Do I have permission to mail to this address? Y N

Email Address _____ Do I have permission to email you? Y N

Home Phone _____ Work Phone _____

Cell Phone _____ Do I have permission to text you at this number? Y N

Sex M F DOB _____ Social Security Number _____ - _____ - _____

Is it acceptable to contact you at home? Y N If "no" then how can I contact you? _____

Are you currently under medical care? Y N If yes, then please explain/describe: _____

Minor Single Years Married _____ Years Separated _____ Years Divorced _____

Name of Primary Physician _____ Phone Number _____

Are you currently taking prescribed medications? Y N
If yes, then please explain/describe. _____

List any psychiatric/mental health medications you have taken (use reverse for more space, if needed) _____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y N
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem. (use reverse for more space, if needed) _____

How were you referred to my office? (check one)

Insurance Company Directory Google Psychology Today Network Therapy Other: _____
My Doctor "Word of Mouth" (If so, who may I thank for referring you to my office?) _____

Emergency Contact/Relation: _____ Phone: _____

Please check any of the following struggles that pertain to you:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Fears/Phobias | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Separation/Divorce | <input type="checkbox"/> Relationships | <input type="checkbox"/> Finances | <input type="checkbox"/> Drug/Alcohol Use |
| <input type="checkbox"/> Career Choices | <input type="checkbox"/> Anger | <input type="checkbox"/> Self-Control | <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Insomnia/Sleep Patterns |
| <input type="checkbox"/> Work/Stress | <input type="checkbox"/> Health Problems | <input type="checkbox"/> Parenting | <input type="checkbox"/> Thought Patterns | <input type="checkbox"/> Spiritual/Religious Matters |

PLEASE ONLY COMPLETE THE FOLLOWING IF YOU HAVE NOT PROVIDED US WITH A COPY OF YOUR INSURANCE CARD:

Primary Insurance

Subscriber's Name _____ Relationship _____

Social Security Number _____ - _____ - _____ Date of Birth _____

Employer _____ Occupation _____

Employer's Address _____ Employer's Phone _____

Insurance Provider Company _____

Group # _____ Subscriber ID# _____

Annual Deductible _____ Has it been met? Y N

Is Pre-Authorization Required? Y N Has it been obtained? Y N

Do you have other insurance? _____

I agree to inform Northwest Counsel if any information on this sheet changes. I understand it is my responsibility to confirm insurance benefits and that I am responsible for all fees, whether or not I have insurance coverage. Northwest Counsel has my permission to bill my insurance company for counseling sessions and follow-up sessions. I authorize the release of any medical information necessary to process these claims. I understand that I am responsible for all charges for services provided, including late cancellation (less than 24 hours notice) and no-show fees, whether or not paid by insurance. I understand that I will be held additionally responsible for all collection and attorney fees necessary to collect fees owed. I understand that all co-payments need to be made at the time of service and that additional billing charges and statement fees may be added to co-payments not made at the time of the session. I understand that I am personally responsible to confirm my insurance benefits and whether or not my therapist is covered by my insurance.

Client Signature

Date