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:

☐Anxiety	☐Depression	☐Fears/Phobias	☐Eating Disorder	☐Sexual Problems
☐Suicidal Thoughts	☐Separation/Divorce	☐Relationships	☐Finances	☐ Drug/Alcohol Use
☐Career Choices	☐Anger	☐Self-Control	☐Unhappiness	☐Insomnia/Sleep Patterns
☐Work/Stress	☐Health Problems	☐Parenting	☐Thought Patterns	☐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**