



Freedman & Associates

# Mental Health Services for Children & Families

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## CLIENT INTAKE FORM

Please complete both sides of form.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_  day  evening OK to leave msg? YES NO

Work Phone: \_\_\_\_\_  day  evening OK to leave msg? YES NO

Cell Phone: \_\_\_\_\_  day  evening OK to leave msg? YES NO

Date of Birth: \_\_\_\_\_ Gender:  MALE  FEMALE

Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION (on card)

Insurance Company: \_\_\_\_\_ Phone#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

ID#: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION (on card)

Insurance Company: \_\_\_\_\_ Phone#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

ID#: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

### PERSONAL INFORMATION

Where were you born/raised? \_\_\_\_\_

Religion: \_\_\_\_\_

Important in up-bringing? \_\_\_\_\_ Now? \_\_\_\_\_

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ For how long? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone #(s): (1) \_\_\_\_\_ (2) \_\_\_\_\_

### COUNSELOR'S NOTES (for office use only)

Date	dx code	dx	Counselor Signature

## MEDICAL HISTORY

(All current medications-including herbal and over-the-counter)

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

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Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

Significant Medical Problems-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Allergies: \_\_\_\_\_

Alcohol Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Drug Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Tobacco Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Caffeine Use-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Have you had previous counseling?  Yes  No

If yes, with whom? \_\_\_\_\_ When? \_\_\_\_\_

Would it help to contact your previous counselor (s)?  Yes  No

## FAMILY SITUATION

Relationship/Marital Status:  Single  Involved  Engaged  Cohabiting  
 Married  Separated  Divorced  Widowed

Marriages, Significant relationships, and children:

Partner/Spouse	From (Year)	To (Year)	Names & ages of children from relationship	Where/with whom do they live?

## GOALS FOR THERAPY

What would you like to see happen as a result of your work here?

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