



Mental Health Services for Children, Adolescents & Adults

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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: \_\_\_\_\_

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

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<br>(Year) | To<br>(Year) | Names & ages of children<br>from relationship | Where/with whom<br>do they live? |
|----------------|----------------|--------------|---|----------------------------------|
|                |                |              |   |                                  |
|                |                |              |   |                                  |
|                |                |              |   |                                  |

## GOALS FOR THERAPY

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

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