# Alderwood Counseling Associates, PLLC

## Client Intake Information

Today's Date:

Name: DOB: Pronouns:

Address: City/Zip:

How can we reach you?

Main Phone: Ok to leave a message? Yes No

Alternate Phone: Ok to leave a message? Yes No

Email:

Parent/Guardian Name: Phone:

Address (if different from above):

Emergency Contact Person and Phone:

Household Members (*Name/Age/Relationship):*

1. 2.

3. 4.

Reason for Seeking Counseling:

Referral Source (*Name/Address*):

Ok to send "Thank You" Note? Yes No

Treatment History (*Mental Health & Substance Abuse*):

Primary Care Physician (*Name/Clinic*):

(*Physician Phone/Address*):

Relevant Medical Condition(s) (*major illnesses/injuries, current/history, recent changes*):

Current Medications (*Dosage, Date Started)*:

Any Legal, Occupation, or Physical problems due to drug/alcohol use: