alderwood
counseling
associates

CLIENT INTAKE INFORMATION

Today's Date: ______________

Name: ______________________________ DOB: ____________ Pronouns: ____________

Address: ____ City/Zip: ________________

Main Phone: ______________________________ ok to leave message? ☐ yes ☐ no

Alternate Phone: __________________________ ok to leave message? ☐ yes ☐ no

Email: ___________________________________

Parent/Guardian name: __________________________________ phone: ________________

Address (if different from above): ____

Emergency Contact: ____________________________________ phone: ________________

Household Members (name/age/relationship): ______________________________________

____

Reason for seeking counseling: ____

____

Referral source: ____

Treatment history (mental health & substance abuse): ______________________________

____

Primary Care Physician (name/phone/address):

____

Relevant Medical Condition(s) (major illness/injury, current/history, recent changes):

____

Current medications (dosage, date started):

____

Any legal, occupation, or physical problems due to drug/alcohol use?:

____