Northwest Counseling
Individual and Family Therapy

CHILD INTAKE FORM

Client Information Forms: This is to be completed by the parent, guardian or family member. Important: If there are court documents regarding custody, please bring to the intake appointment. (Please complete in Ink)

Primary Insurance Company: ____
Effective Date: _______________
(If policyholder is different than client information above):
____
First Name MI Last Name Social Security # _____________________________________
Address: ____
DOB: _________________________
Relationship to Client: ________________________
Employer: ____

Secondary Insurance Company: _____________________________________
Effective Date: _________________
(If policyholder is different than client information above):
____
First Name MI Last Name Social Security # ______________________________________
Address: ____
DOB: _________________________
Relationship to Client: ________________________
Employer: ____

It is your responsibility to inform Northwest Counseling of changes in address, phone #, and insurance coverage.

Parent Name:____
Address (Street and Number):____
City: __________________ State: ___________________ Zip: ______________
Home Phone: (_____) _____-_________
May We Leave a Message
- Yes
- No

Cell/Other Phone: (_____) _____-_________
May We Leave a Message
- Yes
- No

How do you want to receive appointment reminders?
- Email
- Text
- Phone

Northwest Counseling
Individual and Family Therapy

- I do not need reminders

E-mail:
May We Email You?

- Yes
- No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:
Place of Employment:_____________________________________
Work Number: (_____) _____-_________
If needed, is it OK to call here?

- Yes
- No

Emergency Contact:
Name:____
Relationship:_____________________________________
Phone Number: (_____) _____-_________

Referred by:

- Medical Provider: ______________________________________
- Insurance Provider: ____________________________________
- Website: ____
- PsychologyToday: ______________________________________
- Friend/Family: ____
- Other: ____

Have you received any type of mental health services since the last time you were seen at this location?

- Yes
- No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

Name of provider or facility:____

Location:____

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Individual and Family Therapy

Dates of treatment:____

Reason for treatment:____

CHILD
1. Child's Name_________________________________Sex______Age_____DOB________

Grade: _____________Race:__________________ Today's date______________

Please list any changes since the last time the child was seen:

- Family changes (births, deaths, divorces, moves)
  ____
  ____
  ____
- Legal involvement
  ____
  ____
  ____
- Physical Health of child or significant family member
  ____
  ____
  ____
- Use of alcohol or prescription drug
  ____
  ____
  ____
- Use of narcotics or caffeine
  ____
  ____
  ____

What medications, if any, is your child currently taking?
____
____