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**Diplomate in Clinical Social Work**

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## CLIENT INTAKE FORM

Name of Client (1) \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
(2) \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Party \_\_\_\_\_ SS# \_\_\_\_\_-\_\_\_\_-\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_  
Spouse Name & Employer \_\_\_\_\_

Names of children \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

Insurance Company \_\_\_\_\_ Subscriber \_\_\_\_\_  
Subscriber # \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Group # \_\_\_\_\_ Per cent covered \_\_\_\_\_% Deductible \$ \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Reason for seeking counseling \_\_\_\_\_  
Hospitalization(s) \_\_\_\_\_ date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ date \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred by \_\_\_\_\_

Medications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**24-hour Notice required prior to cancel appointments.  
“I understand that I may be charged for appointments if notice is not given.”**

\_\_\_\_\_  
client signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
date