Alison Hadley, LICSW-DCSW

MENTAL HEALTH CONSULTING

509-481-5590

CLIENT INTAKE FORM

Date_____ Name of Client (1)_____Bdate_____
(2)_____Bdate_____

Responsible Party_____ SS#_____
Address_____ City_____ Zip_____
Phone (Home)_____ Work_____ Cel._____

Employer_____
Spouse Name & Employer_____

Names of Children:_____ Age:____ School:_____
_____ Age:____ School:_____
_____ Age:____ School:_____

Insurance Co_____ Subscriber:_____
Subscriber #_____ Bdate_____
Group #_____ Percent covered_____ Deductible_____

Primary Care Physician_____ Phone_____
Address_____Permission to Contact: (Circle) YES NO
Medication(s):_____
Hospitalization(s):_____
Reason(s) for seeking counseling_____
Referred by:_____

24-Hour notice required prior to cancelled appointments. "I understand that I may be charged for appointments if notice is not given."

Signed_____ Date_____