Northwest Counseling and Psychotherapy Center

Therapist _____

Date of First Visit _____

DX _____

CLIENT INFORMATION

Last Name _____ First Name _____ Initial _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Male ☐ Female ☐

Social Security # _____ Occupation _____ Education _____

Employer (or school) _____ Gross Family Income _____

Name of Physician _____ Phone # _____

Physician's Address _____ City _____ State _____ Zip Code _____

Present Medications _____

Allergies _____ Date of Last Exam _____

Referral Source _____

Person to Notify in Emergency _____ Relationship _____

Phone # _____

FAMILY INFORMATION

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Living Together ☐ No. of Years _____

Partner's Name _____ Partner's Birthdate _____

Partner's Education _____ Partner's Occupation _____

Children, Siblings, Others in Home:

Name _____ Relationship _____ Birthdate _____

Name _____ Relationship _____ Birthdate _____

Name _____ Relationship _____ Birthdate _____

Name _____ Relationship _____ Birthdate _____

Please complete the other side.

INSURANCE INFORMATION

Insurance Company #1: _____ Insurance Company Phone # _____

Group # _____ Contract # or Member I.D. # _____

Insurance Company Address _____

Name of Insured _____ Relationship to Client _____

Insured's Birthdate _____ Social Security No. _____ Employer _____

Insured's Address _____

DO YOU HAVE ADDITIONAL INSURANCE: ☐ ***YES*** ☐ ***NO*** ***IF YES, COMPLETE THE FOLLOWING:***

Insurance Company #2: _____ Insurance Company Phone # _____

Group # _____ Contract # or Member I.D. # _____

Insurance Company Address _____

Name of Insured _____ Relationship to Client _____

Insured's Birthdate _____ Social Security No. _____ Employer _____

Insured's Address _____

* * * OFFICE USE ONLY * * *

Case # _____

Therapist _____

BC Benefit Limit _____

Dx _____

ICD-9-CM _____

YTD OPC _____