Lisa M. Hunter, M.A., LMFT
3310 E. Lake Sammamish Pkwy SE, Ste. I
Sammamish, WA 98075

NEW CLIENT INTAKE FORM- Adult

Name _____ DOB ___/___/____ Age _____

Preferred Phone _____ _ □CellPh □HmPh □WkPh Other: _____

Email _____ Preferred Communication □Cell □HmPh □WkPh □Email

May I use email to confirm appointments/ send required forms to? Yes No

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address _____ City _____ Zip _____

May I send mail to this address? Yes No

Employer _____ Type of Work _____

Relationship Status Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact _____Relationship_____Phone_____

Financial Responsibility— *If you will be using insurance benefits, please complete this section:*

Name of Insured _____Date of Birth ___/_____/____

Insured's Employer _____

Insurance Carrier _____Policy/ ID# _____ SS# (if nec. for insurance)_____

Insurance Effective Date: _____ Co-pay amount: _____ Have you met your deductible? Y / N

If you have not yet met your deductible, payment in full is due at the time of service.

Insurance Authorization: I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing my claims or as needed for treatment planning and management required by my insurance carrier.
Assignment of Benefits: I authorize payment of insurance benefits for services rendered to Lisa Hunter, M.A., LMFT.
Financial Responsibility: I understand that if my insurance company should deny payment for any reason, I will be responsible for any outstanding financial debt associated with therapy services.

Referred by/ How did you hear about our services:_____
May we acknowledge our meeting to referral source? Yes____ No____

Client Signature _____ Date _____

Lisa M. Hunter Counseling, LLC | p 425.736.9870 | f 425.491.7293
lisa.m.hunter@comcast.net | lisahuntercounseling.com

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What prompted you to seek therapy?

_____
_____
_____

Who is impacted by the issue?

_____
_____

Others Living in Home (name, age, relationship to client):_____

_____

What have you tried to help manage your current problem? How was it helpful?

_____
_____

What would you like as a desired outcome from seeking counseling?

_____
_____
_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____
_____
_____

Have you had any prior counseling or psychiatric treatment? ____ No ___Yes If yes:
When? _____ Where? _____

Reason for and length of counseling_____
Check one: Therapy was ____ helpful ___ not helpful. Please explain:

_____

MEDICAL / PHYSICAL HEALTH
Name, address and phone number of your primary care physician:

_____
Do I have your permission to discuss or receive treatment records and/ or to receive diagnositic records from your past or current therapist, psychiatrist, and/ or physician to disclose and/or share our clinical information with your past or current therapist, psychiatrist, and/ or physician? Yes____ No____

Date of your last physical exam _____

Have you been under a physician's care for any reason in the last five years? If yes, please explain:

_____

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PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

Aggression	Fatigue	Panic attacks
Alcohol use	Flashbacks	Phobias/fears
Anger	Grief	Poor judgment
Anxiety	Hallucinations	Self-esteem problems
Chronic pain	Heart palpitations	Self-mutilation or harm
Compulsive Behavior	High blood pressure	Sexual difficulties
Concentration problems	Hopelessness	Sleep problems
Cyber addiction	Hyperactivity	Social withdrawal
Depression	Impulsivity	Suicidal thoughts
Disorientation	Irritability	Thoughts disorganized
Distractibility	Loneliness	Trembling
Dizziness	Memory impairment	Unresolved trauma
Drug dependence	Mood swings	Worrying
Eating disorder	Obsessive thoughts	Other (specify)

MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects

Signature (required)_____Date (required)_____

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