Alison Hadley, **MSW/ACSW; LICSW**
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