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CLIENT INTAKE FORM

I. Name: _____ **Date:** _____

Address (please include zip): _____

Phone: Home: _____ **Y/ N Work/Cell:** _____ **Y/ N**

(Please indicate above if I may leave a confidential message on your home or work/cell phone)

E-mail address: _____ **Date of birth:** _____

Emergency contact: _____ **Relationship:** _____

Contact's phone number: _____

II. If you plan on using your insurance to help pay for sessions, please complete the following:

Insurance Plan: _____ **Member ID #** _____

Group # _____

If you are not the primary person on this policy, or if you have a second health plan, please provide the following:

Insured's name: _____ **Date of birth:** _____

Member ID # _____

III. List all the prescription drugs you are taking, and the reasons why they were prescribed:

Name of prescribing doctor: _____

Contact number: _____

Please list the full names and relationships of all people living with you:

IV. Do you have any history of violent behavior (including domestic abuse)? Yes___No___

If yes, please describe: _____

Have you ever been concerned about your use of alcohol, drugs, or other substances? Y___N___

If yes, please describe: _____

V. How did you find out about my practice? If you were referred by another provider, may I contact that person to thank them? (I will not disclose your name).