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Client Intake Form

The information in this form is helpful to me for clinical reasons and also emergency situations.

Name _____ Date _____

Date of birth _____ Referred by _____

Address _____ City _____ Zip _____

Telephone (Home) _____ Work Cell _____

Insurance (If applicable) _____

Insured's Name (if other than yourself) _____ Bill insurance? Yes No

Occupation _____ Employer _____

Emergency Contact Person _____

Relationship _____ Telephone _____

Physician _____ Date of last physical _____

Previous counseling or psychotherapy _____

Current or chronic health problems _____

Regular medications _____

Drug/alcohol use _____

What brings you to therapy at this time? _____

Any other information you would like me to know before we begin? _____
