Mindful Northwest
Affiliate of Northwest Family Life

(Please Print)

Today's Date:	Therapist:	Dx (Code and Description):

CLIENT INFORMATION

Client's last name:	First:	Middle:	☐ Mr. ☐ Miss☐ Ms .☐Mrs.	Social Security no.:

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
☐ Yes	☐ No					☐ M	☐ F

Street address: Email:	Home Phone no.: ( ) Ok to leave a message: ☐yes ☐no	Work Phone no.: ( ) Ok to leave a message: ☐yes ☐no
City: State: Zip Code:	Cell Phone no.: ( ) Ok to leave a msg: ☐yes ☐no	Alternate no.: ( ) Ok to leave a msg: ☐yes ☐no

P.O. box:	City:	State:	County:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Church Affiliation:	
Ministry Involvement:	

INSURANCE INFORMATION

(Please provide your insurance card so we may make a copy.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Name of Primary Care Doctor :	Phone Number:
	( )

Is this person a client here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this client covered by insurance?	☐ Yes	☐ No	
Please indicate primary insurance:		EAP Authorization#:	

Subscriber's name:	Subscriber's ID#.:	Birth date:	Group no.:	Policy no.:	Co-payment:
					$

Client's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Client's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Go to the back of the form>

CLIENT DEMOGRAPHICS

Marital Status	Ethnicity	Household Income/Mo	Sexual Orientation
1 ❑ Single	1 ❑ Caucasian	1 ❑ $0 - $1,499	1 ❑ Heterosexual
2 ❑ Married	2 ❑ African American	2 ❑ $1,500 - $2,499	2 ❑ Gay /Lesbian
3 ❑ Separated	3 ❑ Asian/Pacific Islander	3 ❑ $2,500 - $3,499	3 ❑ Bi-Sexual
4 ❑ Divorced	4 ❑ Hispanic/Latino	4 ❑ $3,500+	4 ❑ Transgender
5 ❑ Widow	5 ❑ Alaskan Native or Native American		5 ❑ Other_____
6 ❑ Cohabited	6 ❑ Multi-racial		

Do you have a disability, which qualifies you for special accommodation or compensation?

_____

Referral Source (Please check the box or boxes that best describe how you chose us as your service provider.)

1 ❑ Relative	5 ❑ Attorney	9 ❑ Radio Ad	13 ❑ NWFL Website
2 ❑ Friend	6 ❑ Church	10 ❑ Radio Show	14 ❑ Internet Search
3 ❑ Counselor	7 ❑ NWFL Client	11 ❑ Yellow Pages	15 ❑ CPS
4 ❑ Court	8 ❑ Doctor	12 ❑ Dept. of Corrections	16 ❑ Insurance Company
			17 ❑ Other

Name of referral person, church or agency_____

FAMILY MEMBERS

Names of Family Members Living w/you	Age	Ethnicity	Any Disability or Health Concerns?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I give my permission for the above information to be used in aggregate form for research, required reporting and funding purposes. I understand that my name, the names of my children and any other identifying information will be kept confidential. Please talk with your therapist if you have a concern with the statement.

Signature_____**Date**_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to NWFL. I understand that I am financially responsible for any balance. I also authorize NWFL or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**