Lynda S. Hiatt, LCSW

License #LCSW14784

Client Intake

Personal Information

Client Name_____ Birth Date_____ SSN_____

Client Name_____ Birth Date_____ SSN_____

Home Phone_____ Work Phone_____ Cell Phone_____

Address_____ City_____ Zip_____

Email_____ Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Others Living at Home

Name	Birth Date	Relationship to You

Name of Closest Friend or Relative_____ Phone_____

Form of Payment

☐Insurance*_____ ☐Cash ☐Other_____

*Please Text a picture of the Front and Back of your Insurance Card to: Lynda (760) 468-6180

History

How Did You Hear About Us?_____ Have You Had Previous Counseling? ☐Yes ☐No

If Yes, Where?_____ When?_____

What Medications Are You Currently Taking?_____

May We Contact the Agency or Person Who Referred You? ☐Yes ☐No

May We Say Who We Are If We Phone Your Home? ☐Yes ☐No Your Work? ☐Yes ☐No

Briefly, What Is the Major Concern or Situation That Brings You Here? _____

Signed _____ Date_____

For Therapist Use Only

Click Here to Submit by Email

Axis I_____ Axis II_____

Axis III_____ Axis IV_____

TX Type_____ Rate_____

Where "Families are First" with Individual and Family Counseling

Office (760) 468-6180 ☙ Fax (951) 677-6712 ☙ familiesrfirst@gmail.com ☙ www.lyndahiatt.com