

Collaborative Couples & Family Counseling, LLC
1601 116th Ave NE, Ste. 102
Bellevue, WA 98004
Phone 425-417-5902
Fax 425-454-1476

New Client Questionnaire

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Cell Phone: _____

Email Address: _____

Partner's name _____ Phone: _____

Email Address: _____

Relationship Status: *Single* *Married* *Widowed* *Divorced* *Separated*

Occupation: _____ Employer: _____

Children: _____ Birth date: _____

Children: _____ Birth date: _____

Others living in the same household: _____ Relationship: _____

Emergency contact Name: _____ Phone: _____

If you have seen a therapist previously, please list the therapist's name and approximate dates:

Please describe the problem you sought help for then: _____

What is the problem or issue you bring in today? _____

What do you want to accomplish in therapy? _____

Do you smoke Yes No

Spouse or partner Yes No

Do you drink alcohol Yes No

Spouse or partner Yes No

Do you use any other substances Yes No

Spouse or partner Yes No

Medical Information:

Please list all medications you are currently taking: _____

Please list any serious health issues or surgeries: _____

Are you currently being treated for any physical or psychological illness? If so, please describe:

Name of treating Physician: _____ Phone: _____

When was your last physical examination? _____

Insurance Information*

**We request payment up front for our services, however if you provide insurance information below, Collaborative Couples & Family Counseling, LLC will bill your insurance company directly as a courtesy. Reimbursement from your insurance company is not guaranteed.*

Name of insurance provider: _____ Policy or ID Number: _____

Insurance Provider Phone: _____ Group Number: _____

Full name of Insured (if different than client's name): _____

Date of Birth of insured: _____

Coverage info: _____

I acknowledge that I am the responsible party for payment of services rendered by Collaborative Couples & Family Counseling, LLC. Payment is due at the time of service unless other arrangements are made in advance. Thank you.

_____/_____/_____
Date

Client Signature

Provider Signature

Client Signature (or Parent / Guardian)