

## Counseling Associates of MA & NH, LLC

Child, Adolescent, Adult, Couple and Family Psychotherapy

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Date of first Session\_\_\_\_\_

## **INTAKE FORM**

Name of Client	Sex MF_
(If the client is under 18, the names of al	l parents/legal guardians)
Emergency Contact	Their telephone
Your Address: Street	
City	State Zip Code
Home Phone ( ) cell (	) work ( )
Client's Date of Birth Marital Sta	tus Preferred Spoken Language
Email Address	
INSURANCE	INFORMATION (Your card will also be copied)
Name of Insurance	
Name of the Insured (if not self)	
I.D. # (this is very important)	Employer
Name of any <i>other</i> insurance (and I.D. #	