New client intake

Welcome to Northwest Psychiatry

Complete the five sections in order. * marks a portal-required item. Fill in the PDF or print clearly; save a separate copy before entering information.

Full name *

Preferred name

Email

Phone *

Date of birth *

Sex *

Height *

Feet

Inches

Weight *

Number

Unit

Pronouns

Gender

Marital status

Employment status

Email: the portal displays your account email as read-only. Record that same email here. **Date format:** MM/DD/YYYY. Enter height in feet and inches, and select the unit used for weight.

Fields do not expand. Check the saved or printed copy for text that does not fit; use a continuation sheet if needed.

Address & insurance

Complete your address, then choose self-pay or enter insurance information.

Full name

Date of birth

Address *

Address line 2

City *

State *

ZIP *

☐ I don't have insurance / I'll self-pay

If checked, skip the insurance fields below and continue to Contacts.

Insurance *

Member ID *

Group number

Insurance phone

Insurance and Member ID are required only when you are not self-paying. Copy these details from your card. The portal's card-scanning feature is not available in this PDF.

Contacts

Emergency contact information is required. Preferred pharmacy is optional.

Full name

Date of birth

Emergency contact

Name *

Phone *

Relationship

Preferred pharmacy (optional)

Pharmacy name

Pharmacy phone

Pharmacy address

First visit details, if already arranged

Practice use only. These are displayed in the invitation wizard, not questions for the client.

Date

Time

Visit type

Brief screenings assigned (if any)

Completing this PDF does not book a visit. Assigned screenings are completed separately in the portal after onboarding.

Allergies

Are you allergic to any medicines, foods or anything else?

Full name

Date of birth

Your provider checks this before prescribing, so please include anything you know of - even a mild reaction.

Choose one response *

◯ I am listing allergies below. ◯ I have no known allergies

If you have no known allergies, leave the rows blank. Otherwise enter each allergen and its type. Reaction details are optional.

1	**Allergen**	**Type**
	What happens? (optional)	
2	**Allergen**	**Type**
	What happens? (optional)	
3	**Allergen**	**Type**
	What happens? (optional)	
4	**Allergen**	**Type**
	What happens? (optional)	
5	**Allergen**	**Type**
	What happens? (optional)	

Need more rows? Attach a sheet with your full name, date of birth, and the same three fields. An unanswered page is **not** a report of no known allergies.

Consents

Please review and accept the following to begin care.

Full name

Date of birth

The first two selections are required. Information sharing is optional.

REQUIRED

☐ I consent to receive telehealth psychiatric treatment from Northwest Psychiatry LLC.

REQUIRED

☐ I understand and accept financial responsibility for services not covered by insurance.

OPTIONAL

☐ (Optional) I consent to sharing my health information with other providers involved in my care.

PDF completion record

Added for this PDF format; these fields are not part of the online wizard.

Completed by

Date

Signature, if required by the practice

Save your completed copy and return it using the method the practice provides. This PDF does not submit to the portal or complete the portal's consent-recording process.