gateways counseling & consulting center

care • compassion • competence

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CLIENT INFORMATION FORM

Today's Date: ____________________

A. Identification

Your name: ____________________________ Date of birth: __________________ Age: _____

Social Security Number: _________________ Home Street address: ______________________

________________________ Apt: ___ City: ____________________________ State: ________

Zip code: ___________ Home/Evening phone number: ________________________________

Cellular phone number (for texting reminders, etc.):____________________________________

Email Address: ____

**Phone calls email, or texts will be discreet, but please indicate any restrictions:*

B. Chief concern:

Please describe the main difficulty that has brought you to see me:

____

____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ___ No ___ Yes If yes, please indicate:

2. Have you ever taken medications for psychiatric or emotional problems? ___ No ___ Yes If yes, please indicate:

____

____

D. Referral

If someone gave you my name to call, may I have your permission to thank the person for the referral? ___ Yes ___ No If yes, please complete the following:

Name: ____ Phone: ___________________

Address: ____

E. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: ___________________________________ Phone: ___________________

Address: ____

____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ___Yes ___ No

F. Your current employer
Employer: _______________________________________ Work phone: __________________

Calls will be discreet, but please indicate any restrictions: _______________________________

____

G. Other:
Is there anything else that is important for me as your therapist to know about? If yes, please tell me about it here or on another sheet of paper.

____
____
____
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