

JAMES M. GIBSON, MS.ED., LPC

Client Information

Name: _____
Street : _____
City: _____ State: _____ Zip: _____
Phone: (H) _____ (W) _____
Cell #: _____
Email: _____
Date of Birth: _____ Age _____
Education: _____
Occupation: _____
Employer: _____
Religion: _____
Medical Conditions: _____
Medications: _____
Allergies: _____
Physician: _____
Address: _____
Phone: _____ Fax: _____

Spouse/Partner/Parent Information

Name: _____
Street : _____
City: _____ State: _____ Zip: _____
Phone: (H) _____ (W) _____
Cell #: _____
Email: _____
Date of Birth: _____ Age _____
Education: _____
Occupation: _____
Employer: _____
Religion: _____
Medical Conditions: _____
Medications: _____
Allergies: _____
Physician: _____
Address: _____
Phone: _____ Fax: _____

INSURANCE COMPANY: _____ **ID # :** _____

GROUP #: _____ **POLICYHOLDER'S NAME:** _____

POLICYHOLDER'S BIRTHDATE: _____

IF YOU HAVE BEEN REFERRED BY AN EMPLOYEE ASSISTANCE PROGRAM (EAP):

NAME OF THE EAP PROGRAM: _____

AUTHORIZATION NUMBER: _____ **AND THE # OF SESSIONS APPROVED:** _____.

**** If I have to file your insurance, please sign below authorizing me to file your insurance and have the payments sent directly to me.**

NAME _____ **DATE** _____

Why are you here? _____

What do you want to be better when you leave? _____

Have you been in therapy before? _____ With whom? _____ When? _____

Children's Names _____ Gender Age School _____ Married? Live with you? _____

Who referred you? _____ Will you give permission for me to thank them? _____