JAMES M. GIBSON, MS.ED., LCMHC

Client Information	**Spouse/Partner/Parent Information**
Name: _____	Name:_____
Street:_____	Street:_____
City:_____ State:____ Zip:_____	City:_____ State:____ Zip:_____
Phone: (H)_____ (W)_____	Phone: (H)_____(W)_____
Cell #: _____	Cell #:_____
Email:_____	Email: _____
Date of Birth: _____ Age _____	Date of Birth: _____ Age _____
Education:_____	Education: _____
Occupation: _____	Occupation: _____
Employer:_____	Employer:_____
Religion:_____	Religion:_____
Medical Conditions:_____	Medical Conditions:_____
Medications:_____	Medications:_____
Allergies: _____	Allergies: _____
Physician: _____	Physician: _____
Address:_____	Address:_____
Phone:_____ Fax: _____	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? _____