

JAMES M. GIBSON, MS.ED., LPC

Client Information

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

INSURANCE COMPANY: _____ **POLICY # :** _____

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

POLICYHOLDER'S BIRTHDATE: _____ **POLICYHOLDER'S SS#:** _____

IF YOU HAVE BEEN REFERRED BY AN EMPLOYEE ASSISTANCE PROGRAM (EAP), PLEASE PROVIDE THE AUTHORIZATION NUMBER: _____ **AND THE NO. OF SESSIONS APPROVED:** _____.

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? _____

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 _____