Gretchen Clemens, LCSW
File Information

Date_____ **Form 1**

Client Name_____ DOB _____/____/_____ Age at intake_____

Issue to be addressed in therapy:_____
(Please state at least one: stress, relationship issues, feelings of being overwhelmed etc.)

Address_____City_____ State/Zip_____

Employer/School (if Student)_____ ☐ not currently working

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Living with Significant Other/Partner

Home Phone: _____ OK to leave message? YES/NO (CIRCLE)

Cell Phone: _____ OK to leave message? YES/NO (CIRCLE)
OK to text for scheduling purposes YES/NO (CIRCLE)

Email Address _____(to be used for scheduling and coordination purposes only)

If client is a minor:

Parent 1 _____ Phone_____ Parent 2_____ Phone_____

Custody: ☐Married parents ☐ Sole custody/Parent 1 ☐ Sole custody/Parent 2 ☐ Joint custody(divorced Parents) ☐ Other

Child resides with: ☐Married parents ☐Parent 1 ☐Parent 2 ☐Divorced parents who split time ☐ Grandparents

Emergency Contacts

Name_____ Relationship: _____

Cell #_____ Home #_____ Work #_____

CURRENTLY PRESCRIBED MEDICATIONS: _____

Physician Release

Primary Care Physician _____Phone_____

Can Gretchen Clemens LCSW Contact your Physician? ☐ Yes ☐No Need/No Authorization Given

Sign if "Yes"_____ Date_____
Client
_____ Date_____
Gretchen Clemens, LCSW

Psychiatrist Contact Information (if applicable)

Current Doctor's Name _____ Phone _____

Can Gretchen Clemens LCSW Contact your Psychiatrist? ☐ Yes ☐No Need/No Authorization Given

Sign if "Yes"_____ Date_____
Client
_____ Date_____
Gretchen Clemens, LCSW