ALLENE GOULD M.S. L.P.C.
Licensed Professional Counselor: Individuals and Parenting Counseling
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NEW CLIENT INFORMATION

Please fill out this form and email it to me before our first appointment.
Please remember to call your insurance company in advance so you know what your coverage is.

- Today's Date: __________

Name: ____Birth date:_____________

Address: ____

____

Cell Phone: ______________________________

Work Phone: ____________________________

Email_____________________________________

*Please note: Email is not considered to be a confidential form of communication

May I leave a message for you or text? Y N At work? Y N On Cell? Y N

Circle one: Single Married Separated Partnered Divorced

Employer (or school):

____

Occupation: ____

Emergency Contact Person: __________________________ Phone: _______________

Primary Physician: _________________________________ Phone: _______________

Medications and Dosage: ❹ None ❹Yes

List:____

____

Who referred you to me?

____

Briefly describe the concern that brings you to counseling at this time:

____

____

____

Have you previously received any type of mental health services? Y N
Was this experience helpful? Y N

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health?
Poor Satisfactory Good Very good
Please list any health problems you are experiencing:

____

____

How would you rate your sleeping habits?
Poor Satisfactory Good Very good

How many times per week do you usually exercise? _________
What type(s): ____

Are you experiencing overwhelming sadness, grief, or depression? Y N
If yes, for how long? ________________________

Are you experiencing anxiety, panic attacks, or have any phobias? Y N
If yes, when did it begin? ________________________
Are you experiencing any chronic pain? Y N
If yes, please describe: ____
Do you engage in recreational drug use? Y N
Do you drink alcohol more than once a week? Y N

Are you currently in a romantic relationship? Y N
If yes, for how long? ________________________

Are there any significant life changes or stressful events that you have experienced recently?

____

____

____

ADDITIONAL INFORMATION
Do you enjoy your work?

____

____

What do you consider your biggest challenges in life?

____

____

What do you consider some of your strengths?

____

____

What goals would you like to accomplish in therapy?

____
____
____

INSURANCE INFORMATION

Name of main insured__________________________________
Insured date of birth: __________
Insured's phone number____________________
Address of insured person_______________________________City ___________
State_________ Zip______________
Relationship of client to insured person_____________________
Employer of insured person____
Insurance Company____________________________________Phone_________________
Insurance identification number__________________________Group number____________