ALLENE GOULD M.S. L.P.C.

Licensed Professional Counselor: Individuals, Couples, & Parenting Counseling

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NEW CLIENT INFORMATION

Please fill out this form and bring it to the first session.

Please remember:

- Call your insurance company in advance so you know what your coverage is.
- **Bring your copay, coinsurance, or full fee with you to the first visit.**
- I take cash, check, or credit card.
- When you enter the lobby on the 4th floor, please tell the receptionists that you are there to see me.
- *If you are ill, or contagious, please reschedule your appointment.*

▪ Today's Date: __________

Name: ____Birth Date: ___________Age: ______

If Child, Parents' Names: ____

Address: ____

____

Home Phone: ___________________________ Work Phone: _______________________________

Cell Phone: _____________________________

Email_______________________________________

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

May I leave a message for you at home 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: ☐ None ☐Yes

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 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____________