Gold Counseling Services

New Client Information Form

Client Name: _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐M ☐F ☐Other

Address: _____
(street) (city) (state) (zip)

Employer/School & Current Grade : _____

Home Phone: _____ OK to leave a message? ☐Yes ☐No

Cell Phone: _____ OK to leave a message? ☐Yes ☐No

Work Phone: _____ OK to leave a message? ☐Yes ☐No

Client Email: _____ OK to email you? ☐Yes ☐No

Primary Care Physician: _____

Client Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Other: _____

How did you hear about our practice? _____

May we thank the referral source? ☐Yes ☐No

PARENT/GUARDIAN INFORMATION (FOR CLIENTS UNDER THE AGE OF 18):

Mother/Guardian Name: _____

Address (if different than above): _____
(street) (city) (state) (zip)

Phone: (Home) _____ (Cell) _____ (Work) _____

OK to leave a message at the numbers above? ☐Yes ☐No

Email address: _____ OK to email you? ☐Yes ☐No

Mother's Occupation: _____ Employer: _____

Father/Guardian name: _____

Address (if different than above): _____
(street) (city) (state) (zip)

Phone: (Home) _____ (Cell) _____ (Work) _____

OK to leave a message at the numbers above? ☐Yes ☐No

Email address: _____ OK to email you? ☐Yes ☐No

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Father's Occupation: _____ Employer: _____

Child currently resides with: ☐Both Parents ☐Mother ☐Father ☐Other _____

Parents' current marital status: ☐Married ☐Separated ☐Divorced ☐Widowed

☐Other (please specify): _____

If remarried, please provide year of remarriage: Mother: _____ Father: _____

Sibling Name(s) of Minor Client	**Age**	**Resides with:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

CLINICAL INFORMATION:

Please briefly describe your reason for seeking therapy: _____

_____

_____

Have you/your child ever been in therapy or received any type of counseling before? ☐Yes ☐No

If yes, please list when, where and with whom you received services and the reason?

_____

_____

Are there any safety concerns about the client (please include past or present concerns)? This may include, but is not limited to, aggressive behavior toward self or others or thoughts of self-harm or suicide.

☐Yes ☐No

If yes, please describe: _____

_____

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Please list any major illnesses and/or hospitalizations if applicable, with approximate dates:

_____

_____

Please list any current medications you/your child is taking (name of medication and dosage, including OTC medication):

_____

_____

_____

Have you/your child had any substance abuse issues? ☐Yes ☐No

If there is any other additional information that that you would like to share, please include it below:

_____

_____

_____

_____