Paul Gillane LMFT
Personal Information (adult)

Name _____ Date _____

Street _____ City_____Zip_____

Age ____ Birthdate _____ Sex ____ Marital Status: *S M D W* Work Phone _____-_____-_____

Who lives with you? _____Cell Phone _____-_____-_____

Education (highest grade / degree completed) _____ Currently a student? ☐ Y / ☐ N

If client is a minor, name of responsible adult _____ Phone _____-_____-_____

Your occupation _____ Email address: _____

Employer Name and address _____

Spouse's occupation _____ Cell phone: _____-_____-_____

Employer Name and address _____

Please write a brief summary of you are seeking help at this time: _____

_____

Please check the problem areas where you feel you need help:

☐ personal relationship	☐ legal / police	☐ drinking problem
☐ marital	☐ sexual	☐ financial
☐ family	☐ emotional	☐ drugs
☐ child rearing	☐ incest	☐ other_____

Previous psychological counseling? ☐ Y / ☐ N Therapist:

_____

Where: _____ Duration: _____

Are you currently taking medication? ☐ Y / ☐ N Type: _____

How did you hear about us? _____

Referring physician's name: _____ Phone number: _____

May we say who we are if we phone your home? ☐ Y / ☐ N … if we phone your work? ☐ Y / ☐ N