# Virginia Gilbert, LMFT

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**NEW CLIENT INFORMATION FORM**

Date_____

**PERSONAL INFORMATION**

Name_____

Address_____

City, State, Zip_____

Home Phone_____ Cell_____

Date of Birth_____ Age___ Gender_____

Occupation_____

Are you currently employed? Yes__No__

Are you in school? Yes___No____

Where?_____

Current relationship status:

Married or primary relationship__ How long have you been in this relationship?_____

If married or in a primary relationship, do you live with this person? Yes__ No__

Children? Yes__ No__ If so, what are their ages?

**MEDICAL INFORMATION**

Name of Physician _____

Phone #_____

Name of Psychiatrist _____

Phone #_____

When was your last physical exam? _____

Are you currently being treated for any illness? Yes_____No_____

If yes, explain:_____

List any major illnesses or operations that you have had:_____

Are you currently taking any prescribed medications? Yes____No_____

If yes, why?_____

Name of Medication_____Dosage_____

Name of Medication_____Dosage_____

List any physical concerns you are presently having (e.g. high blood pressure, headaches, dizziness, etc.):_____

**EMERGENCY INFORMATION**

Name/Relationship_____

Address_____

City, State, Zip _____

Telephone w/Area Code_____

**PRESENTING PROBLEM:**

Why have you come for therapy?

_____

_____

_____

_____

If therapy goes the way you hope, what will be different in your life?

_____

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