Pam Gundlach, LPC

407 Broadway St., #2 ● Eagle, CO 81631 ● 970.306.7607 ● pam@pamgundlach.com

Client Information Form

Today's date ___________________

A. Identification

Client's name: ____ Age: __________

Client's date of birth: ____________________ Client's Social Sec. # ______________________________

Home address:

____

Email address: ____

Home/evening phone: _________________ Work phone: _____________Cell phone: ________________

Which number is best for our office to contact you? *Check all that apply* ___ Home ___ Work ___ Cell

Calls will be discreet, but please indicate any restrictions:

____

____

B. If client is under 18 years of age, please complete this section.
Mother's name: ____________________________ Mother's employer:_____________________________

Father's name: _____________________________ Father's employer: _____________________________

Which parent(s) should our office contact regarding the child's treatment? _________________________

C. Referral: How did you get my name (check all that apply)?

___ Google Search ___ Psychology Today ___ APA Website ___ Facebook
___ Online Yellow Pages ___ News Story ___Phone book ___ Friend/relative ___Medical provider
___ Psychotherapist ___ Psychiatrist ___ Other (specify)_____________________________________

If someone referred you to my practice:

What is this person's name? _____________________

May I have your permission to thank this person for the referral? ___ Yes ___No

How did this person explain how I might be of help to you?

____

____

D. Your medical care: from whom or where do you get your medical care?

Clinic/doctor's name: _________________________________ Phone: ________________________
Address:
____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ___Yes ___No

Credit Card Payment Consent Form

Please be sure to print legibly or type your responses when completing this form. It is essential that we can read all of the information you provide with perfect accuracy. Thank you!

Client Name ____
Print First Middle Initial Last

Name on Card if different ____

I authorize Pam Gundlach, MA, LPC, to charge my credit/debit card for professional services as follows:

Please Initial:

_______ This visit only, for the amount of $ _______________.

_______ All visits in the next 12 months, beginning ___ /___ /___not to exceed $ ____ per charge

Type of Card: □ Visa □ MasterCard

It is my policy to send you an email receipt after I have charged your credit card. Please fill in the email address you would like this receipt sent to:

____

ALL of the following information is required for charges to be made to your credit card. Please be sure to include all requested information and to let me know as soon as any of this information changes. Thank you.

Expiration Date _____________

Credit Card Number _______ - _______ - _______ - _______, CVC Security Number ________

Card Holder's Billing Address for Credit Card Statements

____
Street ***City*** ***State*** ***Zip***

Card Holder Signature _______________________________________, Date ____ /_____ /____

Client Information

Client Name: ____ Date: __________________

Place a check mark next to all of the items below that apply, and feel free to add any others at the bottom. Please note this form is to be filled out regarding the client. You may add a note or details in the margins or on a separate document.

Relationship Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Domestic Partner ☐ Other

Occupation:_____________________ Education:_____________________ Religion:_________________

Are you a veteran? ☐ Yes ☐ No

Are you retired? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No If Yes, Where? ______________________

Members in present house	Relationship to you	Age	Sex	Occupation

Other family members	Relationship to you	Age	Sex	Occupation	Location

Members in house you grew up in	Relationship to you	Age	Occupation	Location

Have you **or** someone significant in your life had any problems in the following areas?

(Check all that apply)	Who? *(i.e.: Self)*	When? *(i.e.: Fall 2003)*
Marital		
Relationship		
Family		
Children		
Employment		
School		
Financial		
Legal		

Death		
Pregnancy / miscarriage		
Abortion		
Physical / sexual abuse		
Changes in living situation		
Experiences you cannot explain		
Feelings difficult to handle		
Alcohol / drugs		

What are your reasons for seeking therapy now?____

If you or someone significant in your life uses drugs or alcohol, please specify who, type of drugs, and frequency of use: ____

How many alcoholic drinks / beers do you or someone significant in your life drink at a sitting?
Please circle and state who:____

None 1 – 3 4 – 6 7 or more

Previous Therapy: Include outpatient treatment, psychiatric hospitalization, dates, therapist names, and reasons

Significant Medical Information List any major medical problems, including hospitalizations and dates of treatment

List all medications, prescriptions and non-prescription you have taken during the last 6 months

List any allergies, current & past? (e.g.: nuts, hay fever, etc)____________________________________

When was your last physical?____________________________ Where?____________________________

List any *drug* allergies?(e.g.: sulfa)____

Emergency Contact Information:

Name	
Relationship	
Address	
City / State / Zip	
Home Phone	( ) -
Work Phone	( ) -