MICHAEL H. GILLOOLY, LCSW-C

NEW CLIENT INFORMATION SHEET

Today's Date:	Referred By (Name, Phone #):		
Name: (Mr.__ Mrs. __ Ms. __) First, Middle Initial, Last:			Sex:
Date of Birth (DOB):			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	
Telephone (Mobile):	Telephone (Home):		
Telephone (Work):			
Telephone (Day):	Telephone (Evening):		
Person to call in case of emergency:			
Employer:	Social Security:		
Marital Status: Single ___ Married ___ Separated ___ Divorced ___	Name of Partner:		
Dependents: Parents, Children or Others Living in the home with you:			
Name:	Age:	Relationship:	
Name:	Age:	Relationship:	
Name:	Age:	Relationship:	
Name:	Age:	Relationship:	
Have you even received counseling before?	Yes _____	No ____	
If yes, do you feel you benefited from it?	Yes _____	No ____	
Additional Information:			