

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:			
Marital Status: Single __ Engaged __ Married __ Separated __ Divorced __ Other _____		Name of Partner:	
Dependents: Parents, Children or Others Living in the home with you:			
Name:	Age:	Relationship:	
Have you even received counseling before?	Yes _____	No _____	
If yes, do you feel you benefited from it?	Yes _____	No _____	
Additional Information: 			