GAHANNA COUNSELING, LLC

540 Officenter Place, Suite 180, Gahanna, OH 43230 Phone: 1-888-336-1772

Client Information

Please make sure that all information is complete before your session begins.
If we do not have this information, we cannot bill your insurance company.

Client Name: _____

Street Address: _____

City: _____State: _____ Zip:_____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ E-mail: _____

Date of Birth: _____/_____/_____ Age: ____ Gender: ☐ Male ☐ Female Social Security # ____ - ____ - _____

Employer/School: _____ Occupation/Grade: _____ Employer/School Phone:_____

Marital Status (of client): ☐ Never married ☐ Domestic partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____

Emergency Contact **Parent(s)/Guardian(s) if client is a minor*

Name: _____

Street Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer phone: _____

Responsible Party Information *If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.*

Responsible Party Name: _____

Street Address: _____City: _____ State: _____Zip: _____

Social Security # ____ - ____ - _____ DOB: ____/_____/_____ Home Phone: _____Cell: _____

Work Phone: _____ Relationship to Client: ☐ Parent/Guardian ☐ Spouse ☐ Other_____

If we need to contact you: Message can be left at (check all that apply): ☐ Home voice mail/answering machine

☐ Cell phone voicemail ☐ Work voicemail ☐ Email (please provide) _____

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Can we send you an email to remind you of future appointments? ☐ Yes ☐ No

Who referred you to this office?

☐ Doctor ☐ Agency ☐ School ☐ Google ☐ Friend/Family ☐ Psychology Today ☐ Other _____

Primary Care PhysicianName:_____

Physician Address: _____Physician Phone: _____

Primary Insurance Company: _____Identification Number on Card_____

Group Number (if applicable): _____*Subscriber Name: _____* *Person who holds the policy*

Subscriber's Social Security Number:____ - ____ - _____ Subscriber's Phone:_____ Cell: _____

Subscriber's Address: _____City: _____ State: ____ Zip: _____

Subscriber's DOB: ____/_____/_____ Client's Relationship to Subscriber: _____

Subscriber's Employer: _____Subscriber's Work Phone: _____

Authorization Number: _____

Please remember, we DO NOT bill secondary insurance. You may bill this on your own. Prior to your 1st appointment, please contact your insurance company to confirm your benefit and network status of your therapist.

What may we help you with? _____How long has this problem persisted?_____

Have you previously been involved in counseling for any reason? ☐ No ☐ Yes

If yes, previous practitioner:_____

Are you currently seeing a psychiatrist? ☐ No ☐ Yes, please name:_____

Have you ever been psychiatrically hospitalized? ☐ No ☐ Yes

1. Date of Hospitalization: _____ Number of days: _____Hospital Name: _____

   Chief reason: _____

2. Date of Hospitalization: _____ Number of days: _____Hospital Name_____

   Chief reason: _____

Are you currently taking any medications (for psychiatric or other reasons)? ☐ No ☐ Yes (please list):

Medication Name	Daily Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____