Lisa Gabardi, Ph.D., LLC

Licensed Psychologist

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CLIENT INFORMATION-Couples/ Families

Please fill out the following to the best of your knowledge. **Date: _____**

Client #1 Name: _____ Birthdate: _____Age:_____

Address: _____

Phone: (H)_____ (W)_____ (Cell)_____
I give permission to be called at (please circle all that apply) **(H) (W) (Cell)**
You may leave a message at (please circle all that apply) **(H) (W) (Cell)**
Email: _____

Would you like to be added to my newsletter with the above email address? _____Yes _____No

Ethnicity: _____ Relationship Status: _____
Number of Years of Education Completed (12= Completed High School**): _____**
Occupation/ Grade in School: _____
Employer/School Name: _____

Client #2 Name: _____ Birthdate: _____Age:_____

Address (if different): _____

Phone: (H)_____ (W)_____ (Cell)_____
I give permission to be called at (please circle all that apply) **(H) (W) (Cell)**
You may leave a message at (please circle all that apply) **(H) (W) (Cell)**
Email: _____

Would you like to be added to my newsletter with the above email address? _____Yes _____No

Ethnicity: _____ Relationship Status: _____
Number of Years of Education Completed (12= Completed High School**): _____**
Occupation/ Grade in School: _____
Employer/School Name: _____

Alternative Communication Channels for the family:

- Yes, Direct Postal Mail to the Above Address (Client #1 or Client #2)
- No, Please mail me at: _____

Restrictions on messages and/or Special Instructions regarding contacting you: _____
_____

Please list all individuals that are living in your household:

Name	***Relationship to You***	***Age***
_____		
_____		
_____		
_____		

Please continue on reverse side if you need more space for family members

Emergency Contact *(person to contact in case of emergency)*
Name: _____ *Relationship to You:* _____
Address: _____ *Phone:* _____
Names:_____ Client information continued

Relationship History:
How we met: _____

How long we dated: _____

Length of time living together/married: _____

Prior marriages/significant relationships, length together, and when they ended:
_____

Prior Use of Mental Health Services (Names of providers and dates seen): _____
_____

Please check all of the following which currently affect your relationship:

_____ I have no problems or concerns
_____ Abuse/Domestic Violence
_____ Anxiety (myself or my partner)
_____ Anger
_____ Alcohol/Drugs (myself or my partner
_____ Alcohol/Drugs (other family members)
_____ Chores/Household duties
_____ Depression (myself or my partner)
_____ Family /In-laws
_____ Financial Concerns/Managing Money
_____ Grief/Death/Loss/Separation/Divorce
_____ Health concerns (mine or my partners)
_____ Infidelity
_____ Legal involvement or concerns
_____ Parenting/Children
_____ Religion
_____ Remarriage/Blended family issues
_____ Sexual concerns(identity, desire, abuse,etc.)
_____ Stress
_____ Work/Employment related problems
_____ Other concern: _____
_____

Who referred you to this office? _____

Briefly describe what brings you to seek counseling now?
_____
_____

What do you want to be different (please be specific) as a result of seeking counseling?_____
_____

Note Regarding Insurance and Relationship Counseling: Insurance coverage tends to reimburse for "medically necessary" conditions. Typically, this will involve assessing that an individual meets criteria for diagnosis of a mental condition. Many insurance companies will not reimburse for couples or relationship related counseling because it is not for the purpose of treating an individual's mental condition.

Insurance Information
Name of Policy Holder: _____ **Relationship to You:** _____
Policy Holder Birthdate: _____ **Policy Holder Social Security #:** _____
Insurance Plan: _____
Insurance Billing Address: _____
_____
Policy Number: _____ **Group Number:** _____

_____ _____
Signature of Client #1 or Personal Representative Date

_____ _____
Signature of Client #2 or Personal Representative Date

This information will be maintained as part of your confidential file with Dr. Gabardi.

Alternative Communication Channels _____ *Accepted*
_____ *Refused* Reason(s):_____
_____

_____ _____
Signature-Dr. Gabardi, Privacy Officer Date