TGIF Counseling, LLC
Treatment Geared to Individuals & Families

Adult Client Information Form

This form is completely confidential

Today's date: _____

Your name: _____
Last **First** **Middle Initial**

Date of birth: _____

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by: _____ -

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

☐ **Yes** ☐ **No**

If referred by another clinician, would you like for us to communicate with them?

☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: Name: **Phone:**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____