Grace Counseling Services

(Please Print) Today's date: ________________

CLIENT INFORMATION (FOR ALL CLIENTS)

Client Name (First, Middle Initial, Last)	Marital status ❑ Single ❑ Married	Sex ❑ M ❑ F	Birth date

Street address	City, State, and Zip Code

Home Phone	Work Phone	Cell Phone
Occupation	Employer or School	Primary Care Physician
Who referred you to this practice?	Have you seen our website? ❑ Yes ❑ No	General Health Status

Any previous counseling? With whom?
List all medications

Emergency Contact	Relationship to client

Home phone	Cell Phone	Work Phone
Responsible for Payment	Home Phone	Cell Phone

Street address	City, State, and Zip Code

IF MARRIED

Spouse's Name (First, Middle Initial, Last)	Birth date	Cell Phone
Occupation	Employer or School	Work Phone

IF A MINOR

Mother's Name	Occupation	Employer

Street Address	City, State, and Zip Code

Home Phone	Cell Phone	Work Phone
Father's Name	Occupation	Employer

Street Address	City, State, and Zip Code

Home Phone	Cell Phone	Work Phone

Siblings (first & last names and ages)

The above information is true to the best of my knowledge.

Patient/Guardian signature _Date_

Payment due at time of service

GCS Counselors are out-of-network for ALL insurance companies