Sharon Gera, LLC
14 Thomas Ave. 1st Floor
Bryn Mawr, PA 19010
(240) 475-2924

CONFIDENTIAL CLIENT INFORMATION

Adult Information

NAME_____ DOB_____

STREET ADDRESS_____CITY _____ZIP_____

TELEPHONE (h)_____(wk)_____(cell)_____

EMAIL_____

OCCUPATION_____

HIGHEST GRADE/DEGREE_____REFERRED BY_____

MAY WE THANK THEM FOR THE REFERRAL? YES / NO

MARITAL STATUS_____PREVIOUS MARRIAGE(s)_____

EMERGENCY CONTACT NAME_____PHONE #_____

Second Client /Spouse/Partner Information

NAME_____ DOB_____

STREET ADDRESS_____CITY_____ ZIP_____

TELEPHONE (h)_____(wk)_____(cell)_____

OCCUPATION_____

EMAIL_____

HIGHEST GRADE/DEGREE_____

MARITAL STATUS_____PREVIOUS MARRIAGE(s)_____

EMERGENCY CONTACT NAME_____PHONE #_____

Treatment Information

CURRENT REASONS FOR SEEKING COUNSELING:

_____

_____

_____

* Please specify whose information - if more than one client.

MEDICAL DOCTOR(s)_____

PHONE#(s)_____

PSYCHIATRIST(s)_____

PHONE #(s)_____

PAST / PRESENT MEDICAL CARE (specify: major problems, accidents, hospitalizations):

_____

_____

CURRENT MEDICATIONS (include dosage):

_____

_____

PAST/PRESENT COUNSELING:

1.Therapist:_____Phone#_____

Initial reason for treatment _____ Length of treatment _____

2. Therapist _____ Phone#_____

Initial reason for treatment _____ Length of treatment _____

LIST ANY CURRENT PHYSICAL SYMPTOMS (such as appetite loss, overeating, low energy, insomnia, headaches, dizzy spells, numbness, epilepsy, chronic pain, anxiety, sweating, shakes, sleep disturbances, etc):

_____

_____

LIST ANY CURRENT EMOTIONAL SYMPTOMS (such as depression, crying spells, anxiety, fear, grief, hearing voices, angry outbursts, suicidal thoughts, nightmares, etc.):

_____

_____

_____

PAST/PRESENT DRUG OR ALCHOHOL USE/ABUSE (includes duration of use, sobriety or recovery, any involvement in AA/NA, etc.):

_____

_____

_____

FAMILY HISTORY OF ALCHOLISM, MENTAL ILLNESS, VIOLENCE OR SUICIDE:

_____

_____

_____

Use space below to give further information.

_____

_____

_____

_____

_____