EduTherapy, LLC
Gail M. Castle, MS. LMHC / LCPC
1033 3rd Avenue SW, Suite 107
Carmel, Indiana 46032

Client Information Form

Last Name	First Name	Middle Initial	Home Phone	Cell Phone

Address	City	State	Zip

Email	Date of Birth	Sex	Marital Status

Emergency Contact

Name	Phone	Relationship

Employment

Occupation	Employer

Additional Information

How did you hear about us?			
Primary Care Doctor	Phone		
Current Medication(s)			
Have you considered? (Please circle Yes or No)	Suicide Yes / No	Harm to Self Yes / No	Harm to Others Yes / No
Previous counseling / psychotherapy (describe)			
Brief Medical History (hospitalizations, surgeries, disease treatment, etc.)			

Correspondence / Messages

May I send correspondence or leave messages?
(Please circle Yes or No)

Home Address	Home Phone	Cell Phone	Email
Yes / No	Yes / No	Yes / No	Yes / No

In the space below, briefly describe the issue(s) bringing you in for counseling:

By signing below, I acknowledge the following:

- I have answered all questions to the best of my knowledge
- I give permission for the emergency contact person to be contacted in case of an emergency.

_____ _____

Signature Date