

Michelle C. Gross, M.A., M.F.T.

CLIENT DATA SHEET

Client Information:

Client Name	Spouse/Significant Other/Parent		
Address	Address		
City/Zip	City/Zip		
Cell Phone	Cell Phone		
Home Phone	Home Phone		
S.S. #	DOB	S.S.#	DOB
Occupation	Occupation		
Wk. Phone	Wk. Phone		
Marital Status: M S D	Marital Status: M S D		

Dependent Information: (list children - whose & which marriage)

Name	DOB	Sex	Parents
Name	DOB	Sex	Parents
Name	DOB	Sex	Parents

Billing Information:

Financially Responsible Party or Insured:	Circle One: Do you wish to use insurance? Yes No
Address	
Home Phone	Work Phone
S.S. #	D.L. #
Insurance Company	
Billing Address	
Phone	Policy #

Payments: All Payments Are Due At The Time Treatment Is Rendered

Emergency Contact	Phone
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Referred By:

Phone

Previous Counseling:

Therapist	Dates	Positive/Negative Experience
Therapist	Dates	Positive/Negative Experience

Current Goals:

(Please List Your Reasons For Counseling At This Time)
