Office of Kelley Costello, LMFT, Inc. - KCG Counseling
10 South Main Street Suite 207 Attleboro, MA 02703 774.322.1306
info@kcgcounseling.com

Client Inquiry Form

Name: _____ Preferred Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Identified Gender: _____ Ethnicity: _____ Date of Birth: _____ Age: _____

Relationship Status*: (Circle all that apply):* Married Single Engaged Separated Divorced Widowed Domestic Partnership Living-Together

Preferred Pronouns: _____

Home Phone: _____ May we leave a VM Message? Yes No

Cell Phone: _____ May we leave a VM / Text Message? Yes No

Email: _____ May we email? Yes No

□ *I understand that writing in my email address (above) is giving explicit consent to KCG Counseling to use that email address to correspond with me in all matters directly related to the provision of services (includes invoicing; appointment bookings, confirmations and reminders; follow-up on services, etc.).*

Parent / Guardian Name (if minor): _____

Parent / Guardian Phone Number (if minor): _____

Emergency Contact Name: _____ Emergency Contact Relationship: _____

Emergency Contact Phone Number: _____

Occupation / School: _____ Referred by: _____

Preferred Day/Time for Service: _____

Name of Spouse / Partner *(if requesting couples counseling):* _____

Spouse / Partner Email *(if requesting couples counseling):* _____

Spouse / Partner Phone Number *(if requesting couples counseling):* _____

Children in the Home? Yes No Ages of Children: _____

Insurance Carrier: _____ Insurance Policy # _____

Insurance Subscriber Information: (*complete if coverage is under a spouse/partner/parent/guardian*)

Subscriber Name: _____ Subscriber DOB: _____

Using EAP? Yes No EAP Authorization # _____

EAP Authorization Dates: _____ EAP Phone Number: _____

Have you ever been seen by a mental health professional before? Yes No

Do you currently smoke *(tobacco)?* Yes No If yes, how often? _____

Do you consume alcohol? Yes No If yes, how often? _____

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Do you use “recreational” drugs? Yes No If yes, what and how often? _____

Please list any troublesome or significant medical conditions you may have:

_____

Are you currently prescribed medication? Yes No

If yes, please provide medication information:

_____

Briefly state your reason for seeking counseling at this time: _____

_____

_____

_____

_____

_____