Karen Lee Gillock, Ph.D.
Cognitive Behavioral Therapy

GENERAL INFORMATION FORM

Date:_____

Demographic Information:

Name:_____

Phone: (Home)_____(Work)_____(Cell)_____

At which phone numbers may I contact you and/or leave messages?_____

Email:_____

May I email you?_____

Home Address:_____

Gender: Male_____Female_____ Date of Birth:_____

Social Security Number:_____

Marital Status: _____

Persons living at home (relationships, not names):_____

_____

Current Employment Status: Full Time_____ Part Time_____

Student_____ Homemaker_____ Retired_____ Disabled_____

Other: _____

Employer:_____ Occupation:_____

How long have you worked there?_____How long in this occupation?_____

Education (list highest level of education attained or last completed grade if currently in school):

_____

Military Experience: _____

Religious Affiliation: _____

Emergency contact name and phone number:_____

Karen Lee Gillock, Ph.D.
115 Etna Road, Building 1, Suite 2
Lebanon, NH 03766
Telephone: 603-448-3588
Fax: 603-448-3583
Email: Karen@Psychologist-NH.com
Web: www.Psychologist-NH.com

Additional Demographic Information (use space as necessary): _____

_____

_____

_____

_____

Referral Information:

How were you referred to Dr. Gillock? Self_____ Family/friend_____ Health Professional _____

Advertisement/Yellow Pages _____ Seminar attendance _____ Other_____

If a health professional referred, please provide name and contact information:_____

_____

May I send a thank you note to the person who referred you?_____

Briefly, what is the issue that prompted this referral?_____

_____

Additional Referral Information (use space as necessary): _____

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Health Information:

Primary Physician:_____Phone:_____

List any significant current health problems:_____

_____

List any significant health problems you have had in the past:_____

_____

List any significant family history of health problems :_____

_____

List any allergies you have or have had in the past:_____

_____

List any medications you are taking and the dosage:_____

_____

List any vitamins and supplements you are taking and the dosage:_____

_____

List any drug, alcohol, caffeine, and nicotine use (current and past):_____

_____

Alternative health practices regularly engaged in (i.e., yoga, chiropracty, etc): _____

_____

Have you seen someone for psychological treatment before? Yes_____No_____

If yes, when and with whom?_____

_____

Give a brief description of treatment:_____

_____

List any significant family history of psychological problems :_____

_____

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Additional Health Information (use space as necessary): _____

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Financial Information:

Financially Responsible Person's Name (if different from the patient):_____

Relationship to Client:_____

Contact Information (if different from above):_____

Insurance Carrier:_____

Group Number:_____Member Number:_____

Credit Card #:_____

Print Name (exactly as it appears on the card):_____

Type: Mastercard_____ VISA_____ Expiration Date:_____

I hereby authorize charges to the above-designated credit card for services rendered by Karen Lee Gillock, PhD, PLLC, in the amounts as outlined in the Treatment Contract. I understand that it is my responsibility to notify Dr. Gillock of changes in credit card companies and/or numbers, and to update the expiration date of my credit card when necessary. I also understand that I can challenge any disputed charges directly with my credit card company.

_____

Signature Date

Additional Financial Information (use space as necessary): _____

_____

_____

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