

**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: \_\_\_\_\_



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Cognitive Behavioral Therapy

**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: \_\_\_\_\_

\_\_\_\_\_

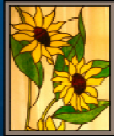
May I send a thank you note to the person who referred you? \_\_\_\_\_

Briefly, what is the issue that prompted this referral? \_\_\_\_\_

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**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? \_\_\_\_\_

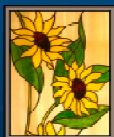
\_\_\_\_\_

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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\_\_\_\_\_  
\_\_\_\_\_  
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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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