Julie B. Gowen, PLLC

Julie B. Gowen, Licensed Clinical Social Worker
16607 Blanco Road, Suite 12101, San Antonio, TX 78232

First MI Last Client Name	Gender: Male Female	Today's Date:

Home Address City, State, Zip	Home Phone # ( ) Cell # ( )
Email address	Date of Birth / Age
Employer	Occupation
Business Address City, State, Zip	Business Phone # ( ) Social Security #

Relational status: ___Single ___Married ___Committed Relationship ___Separated ___Divorced ___Widowed

Number of persons other than yourself living in your household? Adults:_____ Children: _____

Method of contact (check all that apply): ___home phone ___cell phone ___business phone ___email

Religious Affiliation:

o Assembly of God o Baptist o Christian o Church of Christ o Episcopalian
o Jewish o Lutheran o Methodist o Non-Denomination o Presbyterian
o Roman Catholic o Other: o None

Name of Partner / Spouse / Parent / Guardian/Emergency Contact Information (circle one)

First MI Last	Gender: Male Female

Home Address City, State, Zip	Home Phone # ( ) Cell # ( )
Email address	Date of Birth / Age
Employer	Occupation
Business Address City, State, Zip	Business Phone # ( ) Social Security #

Method of contact (check all that apply): ___ home phone ___cell phone ___business phone ___email

Children's Names	Sex	Age	Descriptive Comment

Are you presently seeing another counselor? Y ___ N ___ If yes, whom?

Have you had previous counseling or psychotherapy? Y ___ N ___ When? Where?

Why are you presently seeking counseling?

It is important for your health care providers to speak to each other so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary Care Physician: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
May I contact your physician? ___ Yes ___ No ___ I do not have a physician.

Psychiatrist: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
May I contact your psychiatrist? ___ Yes ___ No ___ I do not have a psychiatrist.

Health conditions your counselor should be aware of:

Medications	Dosage	Reason

Insurance company:	Policy holder:
Policy holder employer:	Policy holder date of birth:
Policy number:	Group number:
Policy holder relationship to client: ___ self ___ parent ___ spouse ___ other (specify):	
Insurance phone number (on card):	
Authorization number:	Copay: Deductible:

CANCELLATION AND MISSED APPOINTMENT POLICY

When you make an appointment for counseling you are reserving that time. If you cancel an appointment without giving adequate notice, that time will be unavailable to others who may need it. Therefore, you may be charged for sessions that you miss, or cancel without giving at least 24 hours notice. Insurance does not pay for a session that is missed.

RETURNED CHECK POLICY

There will be a $35 charge for each returned check.

Who referred you? Name/Address/City/State/Zip

_____

___ I give my permission for Julie Gowen to acknowledge this referral.

Signature _____ Date _____
Client, parent or guardian