Gail A. Phillips, LCSW

2734 N. Hills Drive NE
Atlanta, Georgia 30305
gail@gailphillips.net
(404) 982-9010

Client Intake Form

Full Name _____

Address _____

_____

Primary Phone _____ Alternate Phone _____

Email Address _____

Date of Birth _____ Age _____ Marital Status _____

Referred by _____ Phone _____

May I have your permission to contact your referral source to thank him or her? Yes No

Reason for seeking counseling _____

_____

Is there any other information you would like to share with me today? _____

_____

I understand that I am responsible for all charges incurred, that I must cancel an appointment at least 24 hours in advance or I will be charged for that appointment, and that I am responsible for missed appointment charges.

_____ _____

Signature Date