Gentle Shepherd Counseling Center
1469 South Main Street
N. Canton, OH 44720
330.499.3065 Fax: 330.499.2497

CONFIDENTIAL INFORMATION & CONSENT TO TREATMENT: (PLEASE PRINT)

Name of patient:_____ Age:_____ Sex:_____
Last First Middle

Home address:_____
Street City State Zip

Marital Status:_____ Birthdate:_____ Social Security Number:_____-_____-_____

Phone: Home_____ Cell_____ E-mail_____
*Is it ok to send text messages for reminders or for notifications for openings? ☐ Yes ☐ No

Occupation: (If student, school & grade level)_____

Employer:_____ Address:_____

Emergency Contact:_____Relationship:_____

Phone:_____ **May we leave a message?** Yes_____ No_____

Spouse's Name:_____ Social Security Number:_____-_____-_____

Address (if different from above)_____ Phone:_____

Birthdate:_____ Occupation:_____ Employer:_____

Employer Address:_____ Employer Phone_____

Name of person responsible for payment: _____Phone_____

Address (if different from above):_____

Do you have Medical Insurance that covers mental health treatment: Yes_____ No_____

How did you hear about us:_____ Relationship:_____

Church Affiliation:_____ Pastor:_____

Church Address:_____ Church Phone:_____

Primary Doctor:_____ Practice Name:_____
*Are you willing to sign a form to release information for your counselor to coordinate treatment with your Primary Care Physician? ___ Yes ___ No

Medication currently taking:_____

Do you have any allergies, if so please list _____

Date:_____ Signature _____