Cynthia Gallagher, M.A., MFT
California License, #111045
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San Carlos, CA 94070
(650) 880-3030

CLIENT INFORMATION

Client's Name _____Date of Birth _____

Married___Single___Widowed___Separated___Partnered____Divorced____

Name(s) and Age(s) of Children_____

Name of Spouse or Significant Other_____

Residence Address_____

City _____ State: _____ Zip Code _____

Billing address if other than above _____

Telephone Number (daytime)_____(evening)_____

Email address: _____

Parent's Name if Client is a Minor_____

Person Responsible for Payment _____

Past or Current Occupation_____

Most Recent Employer_____

Nearest Relative (not residing with you)_____Telephone #_____

Emergency Contact_____
Name Telephone Number Relationship

Who referred you to this office? _____

Collection of insurance benefits is the responsibility of the client.
Signature of this form indicates agreement to be responsible for payment of services provided.

_____ _____
Signed **Date**