



Healing | Growth | Guidance

Gurganus Psychological Services, LLC Sara Gurganus, PsyD, LP

Client Information

Name _____ Date of Birth _____

Address _____ City _____ State _____

Zip _____ Gender/Pronoun _____ Marital Status _____ Soc Sec # _____

Employer _____ Occupation _____

Mobile Phone _____ Okay to Leave a Message? Yes No Okay to text? Yes No

Home Phone _____ Okay to Leave a Message? Yes No

Work Phone _____ Okay to Leave a Message? Yes No

Best # to reach you/leave a message: ___Home ___Work ___Mobile

Email _____

In Case of Emergency Notify _____

Relationship to you _____ Phone _____

Referred by _____

May Dr. Gurganus send a thank-you note to the above-named person who referred you to her?

If so, please sign & date here: _____
Signature Date

Person Responsible for Account (if other than client)

Name _____ Date of Birth _____

Address _____ City _____ State _____

Zip _____ Social Security # _____ Employer _____

Employer address _____

Primary Phone _____ Okay to leave a message? Yes No

Relationship to client _____