PROFESSIONAL COUNSELING ASSOCIATES, LLC

Client Information:

Name: _____ Date of Birth:_____
Street Address: _____ S.S.#: _____
City:_____State:_____Zip: _____ Home Phone:_____
Employed by:_____ Work Phone:_____
Marital Status: Married___ Divorced___ Single___ Cell Phone:_____
Separated ___ Widowed ___ Email _____

Responsible Party Information:

Name: _____ Date of Birth:_____
Street Address: _____ S.S.#: _____
City:_____State:_____Zip: _____ Home Phone:_____
Employed by:_____ Work Phone:_____
Email _____ Cell Phone: _____

Spouse Information:

Name: _____ Date of Birth:_____
Street Address: _____ S.S.#: _____
City:_____State:_____Zip: _____ Home Phone:_____
Employed by:_____ Work Phone:_____
Email _____ Cell Phone:_____

Children: (Name and Birthdate)

_____

_____

_____

Referred by: _____
Name & Contact Information

☐ Check box if we may contact the referral source with a letter of appreciation.

Previous counseling experience:_____

What do you hope to gain from therapy?_____

_____

Signature:_____Date:_____