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:______________________
Email: _________________________

Responsible Party Information:

Name: ____ Date of Birth:___________________
Street Address: ____________________________________ S.S.#: _________________________
City:__________________State:________Zip: __________ Home Phone:____________________
Employed by:______________________________________ Work Phone:____________________
Cell Phone:______________________
Email: _________________________

Spouse Information:

Name: ____ Date of Birth:___________________
Street Address: ____________________________________ S.S.#: _________________________
City:__________________State:________Zip: __________ Home Phone:____________________
Employed by:______________________________________ Work Phone:____________________
Cell Phone:______________________
Email: _________________________

Children: (Name and Birthdate)

____

____

____

Referred by: ____

Previous counseling experience:____

What do you hope to gain from therapy?____

____

We appreciate your payment, in full, at the time of service. In the event you will not be able to keep an appointment, you must notify our office 24 hours in advance. If we do not receive such advance notice, YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE SESSION YOU MISSED.

Signature:____Date:_________________________