PROFESSIONAL COUNSELING ASSOCIATES, LLC

Client Information:

Name:_____ Date of Birth:_____

Street Address:_____ S.S.#:_____

City:_____ State:_____ Zip:_____ Preferred Phone:_____

Employed by:_____ Email Address:_____

Marital Status: Single, Married, Divorced, Widowed Referred by:

Responsible Party Information:

Name:_____ Date of Birth:_____

Street Address:_____ S.S.#:_____

City:_____ State:_____ Zip:_____ Preferred Phone:_____

Employed by:_____ Email Address:_____

Spouse Information (If applicable):

Name:_____ Date of Birth:_____

Street Address:_____ S.S.#:_____

City:_____ State:_____ Zip:_____ Preferred Phone:_____

Employed by:_____ Email Address:_____

Children: (Name(s) and Age)

Counseling history: (if so when and reason):

What brings you to therapy?

Payment in full is required at the time of service unless other arrangements are made prior to 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 24-hour notice YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE SESSION YOU MISSED.

Signature:_____ Date:_____