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)

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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:_______________________