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:________________________