PROFESSIONAL COUNSELING ASSOCIATES, LLC

Client Information:

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

Spouse Information:

Name: _____ Date of Birth:_____
Street Address: _____
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:_____