PSYCHOTHERAPY & PASTORAL COUNSELING ASSOCIATES

Therapist _____

Client #_____

Adult client demographic information:

Date_____ Client's Name_____

Address_____
Street City State Zip Code

Home phone _____Work phone _____ Other phone _____

Gender ___ Birth date _____ Age ___ Birthplace_____

Marital Status: Single_____Married_____Divorced_____Widowed_____Other_____

Children: names & ages

_____

_____

Employer_____ Occupation_____

Education _____ Racial/Ethnic Background _____

In case of emergency, contact _____ Phone #_____
Address_____

Religious/Spiritual Preference_____ Church/Synagogue/Practice_____

Referral information

Who referred you to the Psychotherapy & Pastoral Counseling Associates?

_____

OVER

(copy this page for Office Manager)

Reasons seeking therapy

1) Please describe the reasons you are seeking assistance at the Pastoral Counseling Center at this time _____

_____

_____

2) Please check with items below that concern you. Please rate these items as:

1) Mild Concern; 2) Moderate Concern; 3) Strong Concern.

___Anxiety	___Anger	___Religious concerns
___Bereavement	___Self esteem issues	___Loss of faith in God
___Depression	___Fear	___ Loss of faith in self
___Nervousness	___Self doubt	___Loss of faith with others
___Loneliness	___Guilt	___Loss of hope
___Vocational	___Suicidal feelings	___Loss of meaning
___Sexual Abuse	___Relationship with parents	___Loss of self respect
___Sexual concerns	___Relationship with children	___Loss of Love
___Confusion	___Marriage/relatonship	___ Personal Growth

Insurance Company Information

Primary Insurance Name (required) _____

ID #_____ Group #_____

Address: _____ Phone: _____

Secondary Insurance Name (required) _____

ID #_____ Group #_____

Address: _____ Phone: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED: _____ **DATE:** _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described.

SIGNED: _____ **DATE:** _____