Psychological Consultation & Assessment, Inc.
INDIVIDUAL CLIENT INFORMATION

Today's Date ____________

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully or ask your clinician for clarification if you do not understand an item.

Last Name	First Name and MI	
Street Address:		
City:	**State:**	**Zip Code:**

Is it appropriate to send correspondence to this address? ☐Yes ☐No

Home Phone:	Cell Phone:	Work Phone/Ext:
EMAIL:		**Social Security#:**

Age:	DOB:	Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

School:	Grade:
Occupation:	**Education:**

Briefly describe your reason for seeking treatment today:

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List any major health diagnosis, for which you currently receive treatment. Please include any medication you are taking.

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Please list any previous mental health treatment, including names of clinicians and approximate dates of treatment.

Treatment	Clinician

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Please list the members of your family and all others in your home.

NAME	AGE/BIRTHDATE	RELATIONSHIP	OCCUPATION

Please check any of your concerns:

☐Nervousness	☐Depression	☐Fears
☐Shyness	☐Sexual Problems	☐Suicidal Thoughts
☐Separation	☐Divorce	☐Finances
☐Drug Usage	☐Alcohol Usage	☐Friends
☐Anger	☐Self-Control	☐Unhappiness
☐Sleep	☐Stress	☐Work
☐Relaxation	☐Headaches	☐Tiredness
☐Legal Matters	☐Memory	☐Ambition
☐Energy	☐Insomnia	☐Making Decisions
☐Loneliness	☐Concentration	☐Inferiority Feelings
☐Education	☐Career Choices	☐Health Problem
☐Temper	☐Nightmares	☐Marriage
☐Children	☐Appetite	☐Stomach Trouble
☐Bowel Troubles	☐Being a Parent	☐My Thoughts

Please add any additional information which you feel may be useful to us.

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Veterans:

☐	I am a U.S. Military Veteran
☐	I am a family member of a veteran
☐	I have attempted suicide or considered suicide
☐	I have been diagnosed with PTSD, anxiety or a related disorder
☐	I may require family and/or marital counseling

Please indicate any mental health diagnoses:

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Today's Date [ ]

Please initial the space below to indicate receipt and understanding of the following documents:

______ **Fee Schedule and billing form**

______ **Notice of privacy practices**

______ **Informed consent for treatment**

Please initial the space below to indicate receipt and understanding of billing practices:

______ **I have been advised by my insurance company/PC&A of my outpatient mental health benefits. I understand that I am responsible for my copay, coinsurance, deductibles and any other applicable fees at time of service. Please note that PC&A does not participate with all insurance companies.**

I agree to the information contained in the above referenced documents. I grant permission to the staff of PC&A to provide psychological and/or counseling services to the above named individual and I understand I may revoke this permission in writing at any time.

______________________________ ______________
Client Signature **Date**

______________________________ ______________
Signature of parent or legal guardian **Date**

______________________________ ______________
Witness Signature **Date**