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:**	
Gender Identity (optional):	**Sexual Orientation** (optional):	
Ethnicity (optional):	**Preferred Pronouns** (optional):	

Briefly describe your reason for seeking treatment today:

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

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.

_____

_____

Substance use:

I consume alcohol: ☐ Never ☐ Occasionally ☐ Frequently ☐Excessively ☐To Intoxication

I have used opioids: ☐ Never ☐ Occasionally ☐ Frequently ☐ Excessively

I ☐ **have/** ☐ **had an addiction:** ☐ **yes** ☐ **no If yes, identify the addiction:**

_____

I have had treatment for an addiction: ☐ **n/a** ☐ **yes** ☐ **no If yes, Identify type of treatment:**

_____

_____

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

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Please indicate any mental health diagnoses:
_____
_____
_____
_____

Please initial the space below to indicate receipt and understanding of the following documents:
_____ **Fee Agreement and Financial Policy**
_____ **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**