

Pruett Counseling and Consulting, LLC
Information Form (Adult)

PERSONAL INFORMATION

TODAY'S DATE

Name			
<i>first</i>	<i>middle</i>	<i>last</i>	<i>name you prefer</i>
Date of Birth	Age	Email address	
Preferred Phone Number		Employer/School	Occupation/Major
<i>Cell Home Work Other</i>			
Address			
<i>Street address</i>		<i>City</i>	<i>State Zip</i>
Spouse/Partner		Emergency Contact	
<i>Name</i>	<i>Marital Status</i>	<i>Name</i>	<i>Relationship</i>
<i>Phone</i>		<i>Phone</i>	
Religious/Faith Affiliation		Children's Names and Ages	

Rank Importance (Low) 1 2 3 4 5 (High)			
Whom may we thank for referring you to PCandC?			
What issues are you hoping to address/resolve in therapy?			

Name _____

MEDICAL INFORMATION

Primary Care Physician <i>Name</i> _____ <i>Phone</i> _____	Date of Last Visit <i>Month</i> _____ <i>Year</i> _____
Psychiatrist <i>Name</i> _____ <i>Phone</i> _____	Date of Last Visit <i>Month</i> _____ <i>Year</i> _____

PAYMENT INFORMATION

Please complete below if someone else will be responsible for payments on your account	
Responsible Party Name and Phone <i>Name</i> _____ <i>Phone</i> _____	Responsible Party Mailing address <i>Street Address</i> _____ <i>City, State, Zip</i> _____
Responsible Party Email Address	
Please complete below if someone else will be responsible for payments on your account	

INSURANCE INFORMATION

Insurance Company	Name of Insured/Relationship to Client
Group Number	Contract Number
Insured's Date of Birth	Insured's Employer

I affirm that all of the information given above is accurate and complete. If any of the above information changes, I affirm that I will update Pruett Counseling and Consulting as soon as possible.

Signature (Typed name serves as signature)

Date