

PROFESSIONAL CONSULTATIONS AND COUNSELING ASSOCIATES  
12 MAYO PLACE  
DRESHER, PA. 19025  
(215) 646-7932; fax (215) 643-6766

CLIENT INFORMATION

Please fill out the following information form as completely as possible.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_  
(please star the number you wish to be contacted through)

Email address \_\_\_\_\_

\*\*\*FAMILY MEMBERS--PLEASE STAR FAMILY MEMBERS LIVING WITH YOU\*\*\*

Name	Relationship	Name	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\*\*\*MEDICAL HISTORY\*\*\*

Name of Physician \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of last physical \_\_\_\_\_

Past and/or current health problems \_\_\_\_\_

\*\*\*CURRENT MEDICATIONS\*\*\*

Include over the counter medications

Prescriptions	Doses	Since	Physician	Pharmacy
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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\*\*\* PAST PSYCHOTHERAPY\*\*\*

___Therapist	___Psychologist	___Psychiatrist
Date Began_____	Date Ended_____	Medication_____

\*\*\*INSURANCE COMPANY\*\*\*

Primary Insurance Company\_\_\_\_\_

Name of Insured\_\_\_\_\_

\*\*\*GENERAL INFORMATION\*\*\*

The information contained in this form is accurate to the best of my ability. I will inform PCCA when and if any of the above information changes.

I authorize Lynn Benjamin, M.Ed. and/or Robert Benjamin, M.D. to contact any of my previous therapists for the purpose of obtaining information pertinent to my therapy with her or him. I authorize her to release pertinent information to any of my future therapists upon my written or verbal request to do so.

If needed, I agree to have a psychiatric evaluation with Dr. Benjamin. I authorize Lynn Benjamin, M.Ed. to release any information pertinent to facilitate this evaluation.

I understand that Lynn Benjamin, M.Ed. receives regular supervision with Robert Benjamin, M.D. regarding all her cases. I understand that Dr. Benjamin is bound by the confidentiality of this supervisory relationship and will discuss Lynn Benjamin's cases only with Lynn Benjamin. Lynn Benjamin and Dr. Benjamin reserve the right to decide what information is important and pertinent.

I understand that therapy is difficult and may raise unaddressed issues. Although I am expected to benefit from therapy, I understand that there are no guarantees.

I understand that I am coming to see Dr. Robert Benjamin for psychiatric services and Lynn Benjamin, M.Ed. for psychotherapeutic services. I will seek the services of a primary care doctor, an internist, or another medical specialist (such as a cardiologist, a pain management doctor, a gastroenterologist, a surgeon, etc) for any medical conditions that I might have separate from my psychiatric or therapeutic issues.

I have read and understand the above and PCCA's client information sheet.

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Signature

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Date