CATAWBA COUNSELING ASSOCIATES, PLLC

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Welcome to Catawba Counseling Associates

Date: _______________

In order to serve you properly we will need the following information. All information will be strictly confidential. (Please print)

Patient Name ______________________________ Former Name(s)______________________________ Male ____ Female ___

Address____Phone #________________________ Cell Phone # ______________

Race _____________________ Age ______ Date of Birth______________________ **Email Address**__________ __________________

Marital Status: ________ Single___________Engaged _______Married_________ Separated _____ Divorced_________Widow(er)

Highest level of education:____ Degree(s): __________________________

Employed: _______Full-time _____ Part-time _______no If so, occupation:___________________________________

Employer ____

Employer's Address ____ Employer's Phone ___________________________

State briefly and simply your reason for coming to Catawba Counseling Associates, PLLC

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Spouse's Name ____

Race_____________ Date of Birth__________________________ Email Address_____________________________

Spouse's Address: *(if different)* Phone _______________________ Cell Phone ___________________________

Highest level of education: ____________________________College Degree(s) ____________________________

Employed: ____Full-time ____Part-time____ No Spouse's (or Parents') Occupation(s) _______________

Employer____

Employer's Address_____________________________________ Employer's Phone ________________________

Child's/Children(s) name – first & last *(if patient is an adult)* Date of Birth Age Living at home
Use reverse side if more space is needed.

A.____Yes____No__

B.____Yes____No__

C.____Yes____No__

Have you *(or your child)* ever been a patient of this office before? Yes ☐ No ☐ If yes, when ______________

Have you ever been in treatment before? Yes ☐ No ☐ If yes, where? ___________________

Date of last physical: ___________ Physician: _________________ Office/Phone #:__________________

Any significant findings: ___________________________Any chronic health issues: _________________

Please list your medications: ____

Referred by: _________________________________ Address: __________________________________

May I notify referring physician or primary care physician of treatment with Catawba Counseling? Yes ☐ No ☐

Are you a veteran? Yes ☐ No ☐ Is your spouse a veteran? Yes ☐ No ☐

Do you or your spouse have a service connected disability? Yes ☐ No ☐

Consent for treatment

☐ **I authorize Catawba Counseling Associates, PLLC to provide me (or my dependent) with treatment**

☐ I authorize you to contact ____ in case of an emergency.

Relationship to patient: _____________________ Phone # ______________ Cell # ________________

Address: ____

☐ I understand I am financially responsible to Catawba Counseling Associates, PLLC for services. Payment is expected at the time of visit or session may be cancelled. To the best of my ability, the above information is correct.

☐ I agree Catawba Counseling Associates, PLLC may use voice mail, answering machines or email to contact me.

☐ I agree Catawba Counseling Associates, PLLC may video tape my sessions on occasion. These recordings will be used for supervision between the therapist and supervisor to improve treatment or to gain certifications in models used. Recordings will be deleted after consultation occurs. Refusing to authorize recordings will in no way affect your treatment with Catawba Counseling Associates, PLLC.

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Signature Date