

PACIFIC COUNSELING ASSOCIATES

1341 WEST ROBINHOOD DR. SUITE #B10

STOCKTON, CA 95207

PHONE 209.957.9001

FAX 209.957.9004

SCREENING INFORMATION

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Readmit: __Yes __No

Date Client's Social Security # Case #

Client's First Name Last Name MI

Address City State Zip

Telephone (Home) (Work)

Birthdate / / Age Gender __F __M Race

Name of Spouse/Guardian Phone

Address City State Zip

Person Responsible for Payment Soc. Sec. #

Signature of Person Responsible for Payment X (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) Relationship Phone Work

Address City State Zip

Name (2) Relationship Phone Work

Address City State Zip

Physician Phone

Address City State Zip

Psychiatrist Phone

Address City State Zip

Other Physicians Phone

Current Medications

Allergies

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place Phone Hrs

Spouse: Place Phone Hrs

Insurance Information

Primary Insurance Secondary Insurance

Phone Phone

Contract/ID# Contract/ID#

Group/Acct# Group/Acct#

Subscriber Subscriber

Subscriber Date of Birth Subscriber Date of Birth

Client's relationship to Subscriber Client's relationship to Subscriber

__Self __Spouse __Child __Other __Self __Spouse __Child __Other

Referral Source

How did you hear of our clinic (or from whom)?

Address City State Zip

Phone Relationship to referral source