PROFESSIONAL CONSULTATIONS AND COUNSELING ASSOCIATES
Briar House, 8302 Old York Road,
Professional Plaza, B-11
Elkins Park, PA 19027
(215)643-6425, (215)646-7932; fax (215) 643-6766

CLIENT INFORMATION

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

Last Name_____ First_____Middle Initial_____

Date of birth _____Marital Status_____

Address_____

City_____State_____Zip_____

Home phone_____Business phone_____

Cell 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

_____

_____

_____

_____

*** 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.

_____

Signature

_____

Date

_____

Witness

_____

Date