

# The Center for Pastoral Counseling

212 W. Springfield Rd. Springfield Pa. 19064

## Client Information

Date: \_\_\_\_\_ Date of First Session \_\_\_\_\_

Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ OK to leave message? \_\_\_\_\_  
 Yes  No

Cell Phone: \_\_\_\_\_ OK to leave message? \_\_\_\_\_  
 Yes  No

Email: \_\_\_\_\_

GENDER: \_\_\_\_\_ Preferred pronouns \_\_\_\_\_

### RELATIONSHIP STATUS:

Never Married  Married  Living Cooperatively  Divorced  
 Separated  Widow/Widower  Other: \_\_\_\_\_

Spouse/Partner's Name (if applicable):  
\_\_\_\_\_

### ETHNICITY:

White  Black  Asian  Indigenous American  Prefer not to answer  Other:  
\_\_\_\_\_

FAITH PREFERENCE:  Protestant  Catholic  Jewish  Muslim  Hindu  
 Other: \_\_\_\_\_

Congregation Affiliation: \_\_\_\_\_

### HIGHEST LEVEL OF EDUCATION COMPLETED:

Elementary School  Middle School  High School  Some College  
 Bachelors  Masters  Doctorate

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Please list current medications:

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Have you received previous counseling? If yes, what year and with whom?

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Mental health diagnosis \_\_\_\_\_

Suicidal Ideation or attempts \_\_\_\_\_

Have you been hospitalized or admitted to a rehabilitation or treatment center? If so, where?

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Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

In case of concern for others or your life and safety, the counselor may decide to notify the emergency contact person listed on this form.

Your initials here indicate your permission and acceptance of this \_\_\_\_\_.

How did you hear about the Center for Pastoral Counseling?

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If you were referred, do you give permission for the Center for Pastoral Counseling to contact the person to thank them for the referral?

Yes  No

**Statement of Clients Right to Confidentiality**

Center for Pastoral Counseling maintains strict standards of confidentiality and privacy; therefore, you can talk to the counselor openly. These standards of confidentiality are subject to limitations of the law, stipulating responsibility to inform those in a position to intercede when a client is deemed to be in danger to self or others. To ensure the highest quality of care the counselor may consult with another therapist or a qualified psychiatrist. Please sign below to indicate that you have read and understood the above statement regarding your right to confidentiality.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_