Psychological & Counseling Centre, LLC

1201 South Main St., Suite 100
North Canton, Ohio 44720
330 244-8782
fax 330 244-8795
www.vistapcc.com

PATIENT INFORMATION: **Date:** _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ ___ Male ___ Female Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Contact Number (Please circle one): Home Cell Work

Home Phone: _____ Cell Phone: _____ Work Phone: _____

If Minor, Mother's Name: _____

Address (if different): _____ Phone: _____

If Minor, Father's Name: _____

Address (if different): _____ Phone: _____

FOR ADULT CLIENTS OR THE PARENT OF A MINOR CLIENT:

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Name of Spouse/Partner (if applicable): _____

Student Status (for child or adult): ___ Full-time ___ Part-time Attending: _____

Employment Status: ___ Full-time ___ Part-time ___ Retired ___ Unemployed

Place of Employment: _____ Work Phone: _____

Please list others living in the home:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

EMERGENCY CONTACT (at least one person must NOT be living in the home):

Name of Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Name of Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work Phone: _____

REFERRAL INFORMATION:

How did you hear about us? _____

Primary Care Physician: _____ Phone: _____

Have you previously received psychological care? If yes, with whom? _____

PLEASE LIST THE CURRENT REASON FOR SEEKING HELP: _____

_____