Associates at Park Avenue LLC

101 E Park Avenue, Greenville, SC 29601

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Client Information* Date: _____

***For couple's therapy, please complete two separate intake forms.**

Client Name: _____

Referred by:

_____ **Do I have your permission to thank them? Yes No**

Address: _____ **Phone:** _____

_____ **Date of Birth:** _____

Gender: _____ **Soc. Sec. # (Optional):** _____

Marital Status (please circle): Single / Married / Partnered / Divorced / Widowed

Profession/Employer:

Education:

Email Address(s):

Please provide the name/number of an emergency contact:

Other Household member(s):

First name: Last name: Age: Relationship

_____
_____
_____
_____
_____
_____

Medical/Medications:

Name of family physician: _____

Are you currently on any medications or supplements? (include both prescription and non-prescription)

NAME	DOSAGE	REASON	EFFECTIVE?

What medications have you previously taken or been prescribed? Adverse side effects?

NAME	DOSAGE	REASON	EFFECTIVE?

Alcohol & other substances:

Do you: Smoke? Yes ___ No __ How much? _____ How Often? _____

Drink? Yes ___ No ____ How much? _____ How Often? _____

Have you ever used "recreational drugs" or "street drugs"? Yes _____ No _____

PREVIOUS THERAPY, PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Have you previously seen a mental health practitioner? Yes __ No ___If so, whom do/did you see?
_____

What were your reasons for seeking treatment then?_____

What was or was not helpful about it?

_____

Have you previously had formal psychological testing? Yes _ No _ If yes, by whom?

DESCRIBE YOUR GOALS FOR SEEKING COUNSELING AT THIS TIME:

_____
_____
_____
_____
_____
_____

Please note that I am not a Medicare or Medicaid provider and you will therefore not receive reimbursement from Medicare or Medicaid for my services. If reimbursement is very important for you, the best option may be to seek out a Medicare or Medicaid provider.