

Human Relations Associates, Inc., Judith Mishkin Miller, L.C.S.W., B.C.D.
P.O. Box 8312, Asheville, NC 28814, 828-658-3409

Date: _____ Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Street City State Zip Code

Occupation: _____ Business Phone: _____

Business Address: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Social Security Number: _____

Education (highest degree obtained) or Special Training: _____

Marital Status: S M D Sep Widow Previous Marriages: Y N

Name of Spouse: _____ Occupation: _____

Children: Y N If so, please list their names, etc., below:

Name of Child	Gender (M/F)	Birth date	At Home?
---------------	--------------	------------	----------

Reason for your appointment today? _____

Referred by: _____

Have you ever sought psychological help before? _____

Were you on psychological medication? Y N If so, what kind? _____

Currently in therapy? Y N Therapist's Name: _____

Current Physical Health: _____

Major Illnesses: _____

If so, dates of illnesses: _____

Physician _____ Phone: _____

Current Medication: _____

Date of last check-up: _____

Primary Insurance Co.: _____

Group No.: _____

Insurance Co.'s Address: _____

Insurance Co.'s Phone Number (if known): _____

Insured's Social Security No.: _____

Emergency Contact: Name & Phone #: _____

Payment of any and all outstanding bills is the responsibility of the patient and/or guardian.

SIGNATURE AND ACKNOWLEDGMENT OF RESPONSIBILITY