MOUNTAIN VIEW
MENTAL HEALTH

429 Roper Mountain Road, Suite 901, Greenville, SC 29615
Office: (864) 734-7165 | Fax: (864) 203-4587
Email: alex@mtviewmentalhealth.com

Client Information Today's Date: _____

Last Name: _____ First Name: _____ M.I: _____

Date of Birth: _____ Marital Status: _____ Gender: _____

Race: _____ Social Security #: _____ Driver's License/ID #: _____

Cell Phone #: _____ Home Phone #: _____Work Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Email Address: _____

If client is a minor:

Name of Parent/Guardian: _____ Date of Birth: _____

Emergency Contact Name: _____ Phone #: _____

Relationship: _____

Contact Information

Please provide a phone number we may contact regarding your appointments: _____

May we leave a voicemail regarding your treatment at the above number: ◯ Yes ◯ No

Would you like to receive text messages regarding your appointments and treatment: ◯ Yes ◯ No

Medical Information:

Primary Care Provider: _____

Primary Care Practice: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Phone #:_____

Current Medical Conditions:

_____
_____

Current List of Medications (plus, reason for taking and frequency of usage):

_____
_____
_____
_____

Are you currently receiving disability benefits: ◯ Yes ◯ No

Are you currently seeking disability benefits: ◯ Yes ◯ No

History of any/all diagnosed mental health illnesses (including, the approximate date of diagnosis, whether the illness is still present, and what treatment was sought regarding the illness):

_____
_____
_____
_____

Briefly explain your reasons for seeking mental health care:

_____
_____
_____
_____
_____

What are your current goals and hopes for your mental health?

_____
_____
_____
_____