Judith D Alexander, MSW, LISW-CP

315 Miller Rd, Mauldin, SC 29662



| Name: | | Date: | |
|------------------------|------------------------------|---|-----|
| | | | |
| City: | Sta | te: Zip: | - |
| Phones: | home | | - |
| | nome | work | |
| | numbers at which leaving | a message is acceptable. | |
| | | age: | |
| | | | _ |
| Education/occupation | on: | | _ |
| Referred by: | | | |
| If a professional/Drs | office referral, can we than | k them for their referral? Y/N (please circle | le) |
| Address: | uive | | _ |
| Phones: | | | _ |
| Н | ome work | cell | _ |
| Name of physician: | any are taking at this time? | | |
| Please list any allerg | ies: | | _ |
| Please circle any of | the following concerns whic | ch pertain to you? | |
| Nervousness | Loneliness | Self-harm | |
| Shyness | Stomach problems | Suicidal thoughts | |
| Drug Dependence | Parenting | Fears | |
| Anger | Sexual Problems | My thoughts | |
| Sleep Problems | Headaches | Finances | |
| Relaxation | Food/appetite | Self-control | |
| Energy | Memory | Relationship | |
| Sadness | Health problems | Career | |
| What would you like t | o achieve in therapy? | | |