



Park Cities Counseling

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www.parkcitiescounseling.com

Client Intake Information:

Date: _____ Sex: M F Marital Status S M D W

Client
Name: _____

Address: _____

Email
Address: _____

Cell Phone: _____ Emergency
Contact: _____

Family/People who live in your
home: _____

Medical Doctor: _____ Date of last
physical: _____

Psychiatrist: _____

Current
Medications: _____

Current Medical
Conditions: _____

Currently Involved in separation or divorce: _____

If divorced, and I am seeing your child, do you have Joint, Sole, or Possessory Custody?

Have you seen a therapist in the past? _____

If so, please list and the last date you saw them:

Briefly describe why you scheduled your session today: _____

Have you read the Client Informed Consent Form? _____

Initial here: _____ Sessions not cancelled 24 hours in advance will be charged the full fee.

Credit Card Number: _____

Date: _____

CVC: _____

Zipcode: _____