Biltmore Medical Associates
147 Asheland Ave
Asheville, NC 28801

Who referred you to us: _____

Last Name: _____

First Name: _____

Middle Name or Initial: _____

Date of Birth: _____

Sex: _____

Marital Status: _____

Phone Cell #: _____

Phone Home #: _____

Email Address: _____

Home Address: _____

City: _____

State: _____

Zip: _____

Current Employment: _____

Describe the reason for evaluation:

_____

_____

Are you seeking only medication and / or counseling?

_____

Any Alcohol or Drug use: _____

Previous psychiatrist hospitalizations:

_____

Previous psychiatrist or mental health treatment:

_____

Are you currently in a crisis? _____

Are you currently having thoughts of Harming yourself / suicide ideation?

_____

Current Medications with dosage:

_____

Do you currently have insurance or self-pay:

_____

Primary Insurance: _____

Secondary Insurance: _____