Kathy Miller, MS, LPC/MHSP

CLIENT INTAKE FORM

Date___________________

Name:_____________________________ Age: _____ Date of birth: ______________Social Security#:_________________________

Address____ City/State/Zip ____

Phone (Home)_______________________(Work)_____________________ (Pager/Cell Phone)_______________________________

Occupation/Job Title: ______________________________ Place of Employment: ____

Marital Status: **S M D W** Years Married: _______________ Years Divorced/Widowed: _______________________

Spouse's Name_________________________ Spouse's Occupation/Place of Employment: ________________________________

Emergency Contact: ____________________________ Relationship: __________________ Phone #: _________________________

(The questions about Religion and God are optional and are not required.)

Religious Preference: ____________________ Name of Faith Community: ____

Do you consider yourself a religious person? Yes __ No __ Uncertain __ What do you think God feels about you? ________________

____

Individuals living in your home (children and extended family):	*Age:*

Responsible Party: ____ Phone #: ____

Address: ____ City/State/Zip: ___________________________________

Primary Care Physician: ________________________________ Address & Phone #: ______________________________________

Date of last PCP visit: _______________________________ Reason: ____

Medications currently prescribed: ____

Do you have health insurance? Y N (***If you do, please complete page two of the intake form)***

Have you seen a Counselor, Social Worker, Psychologist and/or Psychiatrist before? **Y N** If yes, who: _________________________

Reason: _____________________ How long? ____________ Reason for leaving: ____

____

Rate your emotional health: Very Good ___ Good ___ Average ___ Poor ___ Declining ___ Reason: ___________________________

Legal: (Except for minor traffic violations. Were you arrested, convicted and/or court-marshalled for violations(s) of the law?

____

At your home are there firearms? **Y N** If yes, how are they secured? ____

Have you been hospitalized for a mental condition? **Y N** If yes, what was the reason and name of the hospital? _______________

____

What problem prompted you to come in today? ____

____

How did you hear about me? **Internet Psychology Today Word of Mouth Insurance Company Medical Referral**

What is your email address? ____

I attest that all this information is true and correct.

Signature: ____ Date: ______________________________

Health Insurance Information		
Primary Insurance:	**Insurance ID #**	**Group #**
Secondary Insurance:	**Insurance ID #**	**Group #**
Is the insurance in your name or another family member's name? Yes No		
If yes: Insured's Name:	**Insured's Social Security #**	**Insured's DOB**
Person or Authorized Person's Signature: I authorize the release of any medical or information necessary to process all claims filed with my insurance provider(s). I authorize the payment of medical benefits to Kathryn A Miller, MS, LPC/MHSP for outpatient behavioral health services. **Signed:**		
Date:		