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? _____

Children's Names	**Age**	**Address (if different from above)**

Responsible Party_____ Phone_____

Address:_____City/State/Zip _____

Primary Care Physician: _____Address/Phone #_____

Last time you saw your PCP: _____ Reason: _____

Medications currently using:_____

Do you have health insurance **Y N** ***(If Yes, please complete the questions on back side of this page)***

Have you seen a Counselor, Psychologist or Psychiatrist ? **Yes No** 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 ever arrested, convicted and/or court-martialed for violation(s) of the law?

Yes __ No __ If yes, explain: _____

At your home are there fire arms present? **Y N** ***If yes, How are they secured?*** _____

Have you ever been hospitalized for a mental condition? **Yes No** If yes, for what reason and what hospital: _____

_____

What is the problem that has prompted you to come in today? _____

_____

How did you hear about me? **Circle one:** **Insurance Company** **Psychology Today** **Word of Mouth** **Doctor's office** **Website:**

e-mail address: _____

I attest that the above information is truthful and correct.

Signature: _____ Date: _____

Kathy Miller, MS, LPC/MHSP

4646 Poplar Ave. Suite 424 Memphis, TN 38117 (901)767-4748

Health Insurance Information		
Patient Name:	**Social Security Number:**	
Primary Insurance Name:	**ID Number:**	**Group Number:**
Date of Birth:		
Address:		
Secondary Insurance Name:	**ID Number:**	**Group Number:**
Is the insurance in your name or are you covered under another family member's policy? (Circle one) Y N		
If Yes: Insured's Name:	**Insured Social Security Number:**	
Insured's Date of Birth:		
Patient or Authorized Person's Signature: I authorize the release of any medical or other 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:**	

Kathy Miller, MS, LPC/MHSP 4646 Poplar Ave. Ste 424 Memphis, TN 38117 (901) 767-4748