STEPHANIE D. MILLER, MA
LMFT, LPC, LCDC
Helping Individuals, Couples and Families Change and Grow

Individual Client Information

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Professional Services Agreement and Informed Consent Form and the HIPAA Notice of Privacy Practices contained therein. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ DATE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: Home: _____ Office: _____

Cell: _____ Fax: _____

E-MAIL: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: If same as above, write, "Same as above"

Address: _____

Phone: _____ Text: Yes or No *Circle One*

Email: _____

HIGHEST GRADE/DEGREE: _____TYPE OF DEGREE:_____

EMPLOYER: _____ OCCUPATION:_____

PERSON AND PHONE NO. TO CALL IN EMERGENCY:

_____

REFERRAL SOURCE: _____

What is your goal for therapy? _____

_____

What have been most significant changes, losses, or transitions in the last 5 years of your life?

_____

_____

_____

FAMILY/RELATIONSHIP INFORMATION:

Current Relationship Status – *Check all that apply*: ❑ Married ❑ Single ❑ Divorced

❑ Separated ❑ Engaged ❑ Involved in a serious Relationship since (date) _____

If you are currently married, how long have you been married? _____

SPOUSE NAME: _____ AGE: _____ OCCUPATION: _____

Have you been married before? _____

How long did each prior marriage last? 1st _____ 2nd_____ 3rd_____

Do you have any children? ❑ Yes ❑ No *Use the back of page for additional information.*

Child's Name	Age	From Marriage or Relationship #	Live with You

List the NAMES and RELATIONSHIPS of others living in your home:

_____

_____

SIBLINGS (names/ages): _____

PARENTS/STEPPARENT(s) (Ages or year of death): _____

_____

MEDICAL DOCTOR(S): _____ PHONE(S): _____

LAST EXAM: _____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations):

_____

Specify all MEDICATION you are presently taking and for what. PRINT clearly:

_____

_____

Are you currently seeing another mental health professional? ❑ Yes ❑ No

If yes, what is the focus of therapy?

_____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Therapist: _____ Dates: __ to __Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

2. Therapist: _____Dates: __ to ___ Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):_____

_____

On a scale of 1-10, how important is spirituality to you? _____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, browsing, etc.): Facebook: _____ YouTube: _____ Gaming: _____ Browsing: _____ Other: _____

What gives you most joy or pleasure in your life? _____

_____

_____

What are your main worries and fears? _____

_____

_____

What are your most important hopes or dreams? _____

_____

_____

Additional comments: _____

Use the space below if you need to provide additional information.

_____

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