LINDA K MILLER, LMHC

Welcome!

Please read the following helpful guidelines:

1. Cancellations must be made within 24 hours to avoid being charged a fee of $50
2. Please contact your insurance company to verify your mental health benefits. The information I get on your behalf is not guaranteed to be accurate by your insurance company.
3. You may be contacted via email, postal service, phone or text. I will leave messages on any phone number that you provide. If you have specific instructions for example, not to be contacted at work, please let me know here.
   Your specific instructions:_____

I have read and understand the above:_____ Date:_____

Patient Information: (PLEASE PRINT)

Patient Name:

Last_____First_____MI_____

Street Address: _____

City:_____State_____Zip_____

Phone: Home (_____)_____-_____ Cell (_____)_____-_____

Sex: _____F _____M ____Other Married_____ Divorced_____ Single_____ Widowed_____

Social Security Number_____-_____- _____ Date of Birth _____/_____/_____

Email:_____

Emergency Contact:_____

Phone (_____)_____-_____Relationship_____

Referring Physician:_____Phone (_____)_____-_____

Insurance Information: (PLEASE PRINT)

Name of Insurance:_____ Ins. Co Phone (_____)_____-_____

Group Number:_____ Member ID Number:_____

Policy Holder Name:_____Policy Holder Date of Birth_____/_____/_____

Policy Holder Social Security Number: _____-_____-_____

Policy Holder Phone (_____)_____-_____

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Clinician Requirements and Patient Responsibilities

Please read the following guidelines:

Your records and my communication will be kept in accordance with State and Federal Law. A copy of the privacy policy described in the HIPPA ACT of 1996 is available for your review.

The following is a list of exceptions to the law (confidentiality):

- Disclosure of child abuse
- Disclosure of your intention to harm another person
- Your inability or refusal to keep yourself from self-harm
- Disclosure of abuse to vulnerable adults

I understand that if I am using my insurance for coverage of sessions, Linda Miller will need to provide treatment information to that company in accordance with the company's rules and regulations. I agree to make full payment or co-payment at the time of the appointment.

I have the right to be treated respectfully and I will treat our appointments with respect. I will cancel my session at least 24 hours in advance. If I cancel or reschedule within 24 hours, I agree to pay the **cancellation fee of $50.**

A client may be terminated non-voluntarily, if the client exhibits physical violence, verbal abuse, carries a weapon, or engages in illegal acts in the office, or does not make a payment or payment arrangements in a timely manner.

I have read and understand the above. I consent to treatment. I have been given the opportunity to review the HIPPA privacy policy.

_____ _____

Signature of client Date

If Treatment is for a minor child:

I give my consent for the treatment of _____

I agree to participate in the therapy session as requested by Linda Miller

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Initial Client Assessment

How did you hear about me?_____

Name:_____Age:_____Date:_____

Why are you seeking counseling at this time:_____

_____

How long have you had this problem?_____

Please describe current symptoms:_____

_____

Psychiatric History

Describe any previous in-patient or out-patient psychiatric treatment including dates and names of Physicians or

Therapists:_____

_____

_____

_____

Wat was /were your previous diagnosis(s)?_____

List all Medications you are **currently** taking (includes over-the-counter or herbal remedies) If needed continue on other side.

Medications	Dosage (if Known)	How long on it

Do you have any drug allergies?_____If yes please list:_____

_____

Describe any suicide attempts:_____

	AMOUNT	FREQUENCY
Caffeine		
Tobacco/Cigarettes		
Alcohol		
Marijuana		
Cocaine/Crack		
Other		
Other		

Have you ever been treated for substance abuse or are you recovering presently?

Family Psychiatric History

Does anyone in your family have a history of mental health problems?

Has anyone in your family had problems with drugs or alcohol?

Medical/Surgical History

What illnesses do you currently have?

What surgeries have you had?

Have you ever had a head injury or loss of consciousness?

What medication(s) have been tried in the past for your diagnosis?

Are you currently having problems with any of the following?

Eyes Ears Nose Throat Heart Lungs Gastrointestinal

Urinary Tract Skin Endocrine Lymph Nodes Neurological

Sleep History

What time do you get to bed?

What time do you fall asleep?

Do you sleep through the night? Yes? No?

Do you nap? Yes? No?

What time do you wake up for the day?

Reproductive History - FEMALE

Are you sexually active? Do you use birth control? Describe:

At what age did your start your menstrual cycle? Are your cycles regular?

How long do your cycles last?

Pregnancies: Full Term Premature Miscarriages Abortions

Living children

Reproductive History - MALE

Are you sexually active? Do you or your partner use birth control?

Living children

Personal and Social History

Have you been married? If so, the name of your spouse

Highest level of education completed Occupation

Have you been in the military?

Have you ever had legal problems? Describe

Have you ever been abused in any way? If so, when did it occur and were you ever treated?

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult

Name:_____ Age_____ Sex: ☐ Male ☐ Female Date:_____

*If this questionnaire is completed by an informant, what is your relationship with the individual?*_____
In a typical week, approximately how much time do you spend with the individual?_____hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

	During the past TWO (2) WEEKS, how much (or how often) have your been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half of the days	**Severe** Nearly Every Day
I	1 Little interest or pleasure in doing things?	**0**	**1**	**2**	**3**	**4**
	2 Feeling down, depressed, or hopeless?	**0**	**1**	**2**	**3**	**4**
II	3 Feeling more irritate, grouchy, or angry than usual?	**0**	**1**	**2**	**3**	**4**
III	4 Sleeping less than usual, but still have a lot of energy?	**0**	**1**	**2**	**3**	**4**
	5 Starting lots more projects than usual or doing more risky things than usual?	**0**	**1**	**2**	**3**	**4**
IV	6 Feeling nervous, anxious, frightened, worried or on edge?	**0**	**1**	**2**	**3**	**4**
	7 Feeling panic or being frightened?	**0**	**1**	**2**	**3**	**4**
	8 Avoiding situations that make you anxious?	**0**	**1**	**2**	**3**	**4**
V	9 Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	**0**	**1**	**2**	**3**	**4**
	10 Feeling that your illnesses are not being taken seriously enough?	**0**	**1**	**2**	**3**	**4**
VI	11 Thoughts of actually hurting yourself?	**0**	**1**	**2**	**3**	**4**
VII	12 Hearing things other people couldn't hear, such as voices even when no one was around?	**0**	**1**	**2**	**3**	**4**
	13 Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	**0**	**1**	**2**	**3**	**4**
VIII	14 Problems with sleep that affected your sleep quality over all?	**0**	**1**	**2**	**3**	**4**
IX	15 Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	**0**	**1**	**2**	**3**	**4**
X	16 Unpleasant thoughts, urges, or images that repeatedly enter your mind?	**0**	**1**	**2**	**3**	**4**
	17 Feeling driven to perform certain behaviors or mental acts over and over again?	**0**	**1**	**2**	**3**	**4**
XI	18 Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	**0**	**1**	**2**	**3**	**4**
XII	19 Not knowing who your really are or what you want out of life?	**0**	**1**	**2**	**3**	**4**
	20 Not feeling close to other people or enjoying your relationships with them?	**0**	**1**	**2**	**3**	**4**
XIII	21 Drinking a least 4 drinks of any kind of alcohol in a single day?	**0**	**1**	**2**	**3**	**4**
	22 Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	**0**	**1**	**2**	**3**	**4**
	23 Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)					