

# CLIENT INFORMATION

DATE:

Please print clearly or type

EMMETT E. MILLER, M.D.

PATIENT/CLIENT INFORMATION	Last Name	First Name	M.I.	Marital Status	Age	Birthdate	
	Home Address			City	Zip Code	Home Phone	
	Mailing Address if other than above		City	Zip Code	Social Security No.	Work Phone	
	What is your occupation/profession?						
In case of emergency, contact:							
FAMILY INFORMATION	Spouse's last Name		First Name		M.I.		
	Spouse's occupation/profession?						
	Children: (Please include Name/Sex/Age)						
CURRENT MEDICAL CARE	How did you hear about Dr. Miller? (If referred please give name and address of referral source)						
	Name of present primary care physician (Family Doctor, Internist):				Address and Phone Number:		
	Are you currently undergoing medical therapy?    Yes <input type="checkbox"/> No <input type="checkbox"/> if "Yes", please describe:						
	If under the care of a medical specialist please include their Name/Specialty/Address/Phone Number						
	Are you currently in counseling or undergoing psychotherapy? (including family or couples counseling) Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please describe:						
MEDICAL HISTORY	Name of psychotherapist (if any)			Address and Phone Number:			
	List <u>all</u> current medications including dosage:						
	Any prior experience with relaxation therapy, biofeedback, hypnotherapy, meditation or other Mind-Body approaches?    Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please describe:						
Describe any past hospitalizations, include dates: (except childbirth, tonsils and minor problems)							
Describe any present physical or other health problem(s):							

In order to save time during our initial visit, please answer the following background questions. If, for any reason you would rather not answer in writing indicate this and we will discuss during your first visit

What are the desired outcomes or goals of your work with Dr. Miller?

Have you seen other professionals for this purpose? Yes  No  If "Yes", please explain:  
(include Who and When)

Are there any issues or conditions (physical, mental emotional, social, spiritual or behavioral) that may have a bearing on what you want to accomplish here? Yes  No  If "Yes", please explain:

What is the **general** state of your health?

How do you rate your <b>diet</b> and nutritional habits?	Excellent	Good	Fair	Poor	Please note any important information
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

How do you rate your <b>exercise</b> program?	Excellent	Good	Fair	Poor	Please note any important information
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

How do you rate your <b>relationships</b> with others?	Excellent	Good	Fair	Poor	Please note any important information
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Do you use alcohol, cigarettes or other drugs on a regular basis? Yes  No  Indicate amounts used:

Has there been significant alcohol or drug usage in your immediate family or family of origin (spouse, children, parents, etc.)? Yes  No  If "Yes", please explain:

Has there been a history of depression in your family? Yes  No  If "Yes", please explain:

List any allergies to medications, or significant side effects:

My work with most people does not involve the use of medication - in fact, many who are using medications find they are able to reduce or stop. Sometimes, however, the judicious use of selected agents may be valuable. What are your feelings about using medications?

- Absolutely no medication under any circumstances
- Very resistant to medications, but would consider
- Would prefer not to use medication, but open to them if necessary
- Believe strongly that I need medication

### Focus Of Treatment

I understand that Dr. Miller offers counselling, psychotherapy, relaxation therapy, stress management, hypnotherapy and other modalities of Mind/Body treatment and counseling. I am not consulting him in expectation of a complete physical examination, diagnostic workup or general medical therapy, and I understand that the services he offers are not intended as a substitute for primary medical care.

### Payment Of Fees

I understand that I am financially responsible for all services performed whether or not they are covered by insurance. Unless otherwise agreed upon in writing, I agree to pay for each service at the time it is rendered.

### Authorization

I authorize Dr. Miller to release any information required by my insurance company, which they request in writing, in order to authorize payment(s) of my claim(s).

I have read and agree with the foregoing. The information I have given is accurate to the best of my understanding.

Signature \_\_\_\_\_

Signature of parent if client is under the age of 18 \_\_\_\_\_

Date \_\_\_\_\_