Demographic Information

Client Name: ___________________________________ DOB: _____________________________
*The "client" is the person receiving services or if using insurance, has the clinical diagnosis.

Guardian Name (if minor): ____
First Last Relationship

Address:____
Street Address City State Zip

Email address: ______________________________________Ok to contact via email? Yes No
Email communication is best used for making contact regarding appointments and other basic information and would not be used as a therapeutic tool or to communicate confidential information.

Phone Numbers: Cell: _________________ Work/Other: __________________

Best number to contact you: _______________ Ok to leave messages at that number? Yes No

SS Number: ________________________________ Circle one: Female/ Male/ Other Age: ____

Marital Status: ___ Married ___ Divorced/Separated ___ Widowed ___ Partnered ___ Single

Emergency Contact: _______________________________________ _______________________
Name and Relationship Phone number

I give permission for my therapist to contact my emergency contact or seek emergency services if needed.

____ ______________________
Client/ Guardian signature Date

Are you currently in school? Yes No Highest grade achieved to date: ____________________

Currently Employed? Yes No Full time Part time at: _________________________________

Medical Information:
Physician
____
Name Address Phone
Psychiatrist
____
Name Address Phone

How did you hear about Beth Miller, LCSW?

What are you hoping to achieve through counseling services?