

## CLIENT DATA FORM (*confidential*)

**1**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Name(s) of other individual(s) attending therapy with you: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Have you been in therapy before? Yes \_\_\_ No \_\_\_

Occupation: \_\_\_\_\_ School/University (students): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ (May I leave a message on this number?)  YES  NO Work Phone: \_\_\_\_\_  YES  NO Cell: \_\_\_\_\_  YES  NO 

E-mail: \_\_\_\_\_

**2****How did you hear about me?**  General internet search  Aetna directory The Family & Marriage Counseling Directory ([www.family-marriage-counseling.com](http://www.family-marriage-counseling.com)) National Registry of Marriage Friendly Therapists ([www.marriagefriendlytherapists.com](http://www.marriagefriendlytherapists.com)) National Directory of Marriage and Family Counseling ([www.counsel-search.com](http://www.counsel-search.com)) Google ad (not regular Google search results, ads appear on the right side of your search results) Personal recommendation (name) \_\_\_\_\_  Professional referral: (name) \_\_\_\_\_ Psychology Today  News/media  Other: \_\_\_\_\_**3****Emergency Contact Person:**

Phone (home/cell): \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

I give permission for Mr. Miller to contact this individual in case of an emergency.

\_\_\_\_\_  
Signature of Client\_\_\_\_\_  
Date**4****Person to be named on therapy billing statement (only needed if other than yourself):**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

(Print address below if this person is not attending therapy with you)

**5****Are you seeing another therapist or psychiatrist currently?** Yes \_\_\_ No \_\_\_

Name(s): \_\_\_\_\_

(Please fill out *Release of Information* form and will discuss with you if it is necessary for me to coordinate treatment)**6****Would you like a FREE subscription to *Compass*, my bi-monthly e-newsletter (6 issues per year) that gives you ideas and tips about emotional intelligence, relationship fitness and mind/body health? (You can easily unsubscribe at any time).**

Yes \_\_\_ No \_\_\_

**OFFICE USE ONLY****DIAGNOSIS:**  
**BASIC FEE:****OPENED:**  
**CLOSED:**

## Authorization for Care

I, the undersigned, have received and read the Client-Clinician Agreement provided by Keith A. Miller, LICSW, and I authorize him to provide the services of psychotherapy and/or counseling to me.

I understand that the psychotherapy/counseling services provided to me are by appointment only and may not be available on an emergency basis.

I am aware of the cancellation policy and know that I will be charged for a full session if I miss an appointment or cancel within 24 hours notice.

\_\_\_\_\_  
Printed Name \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name (partner or family member) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature



