Schelle Miller, Ph.D.

APPLICATION FOR SERVICES
ADULT FORM

Today's Date: _____

Client's Name: _____ **Date of Birth:** _____ **Age:** _____

Gender: _____ **Race/Ethnicity** _____

Phone Number(s): (Cell) (Home) (Work)

May we leave a message? _____

Emergency Contact: _____ Rel: Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (If Different from above): _____

City: _____ State: _____ Zip: _____

Email Address: _____

Highest Grade or Degree Completed: _____

If a current student, list college or school: _____

Marital Status: _____ **# of Years:** _____ **# of Previous Marriages:** _____

Occupation: _____ **# of Years:** _____

Please list others who currently live in your home:

Name	*Relationship*	*Age*	*Gender*	*Occupation*

Please list other family members who do not live with you:

Name	*Relationship*	*Age*	*Gender*	*Occupation*

Who referred you to my office or how did you hear about my services?

What is your reason for seeking therapy at this time?

Is there any family history of mental health issues? _____ If so, who and what type of issue:

List any major health problems:

List Current Medications:

Who is your Primary Care Physican? _____ Phone number: _____

Have you ever received counseling or mental health services before? _____ If so, please list the counselor(s) or doctor(s): Name, City, Reason for Service and Approximate Dates of Service

Have you ever been hospitalized for emotional or mental health reasons? _____ If so, please list: Name of the hospital, City, Approximate Dates of Service and Reason for Hospitalization.

Please notify me if any of your contact information or insurance changes.

The information I have given in this application is acurate and complete. I have the legal right to consent for services and I am freely seeking professional counseling or psychological services at this time.

Client Name (printed): _____

Client Signature: _____ Date: _____