Nathan J. Miles, PhD
Counseling & Psychological Services

80 Codell Drive, Suite 160
Lexington, KY 40509
Ph: 859-379-9721
www.drnathanmiles.com

Client Information Sheet

Date _____

Your answers to these questions are confidential and are helpful in determining if these services are most appropriate, as well as for treatment planning. If you have any questions regarding these items, please discuss them with the therapist.

Name_____ **SS #**_____
First Middle initial Last

Address
_____
Street Apt.
_____
City Zip

OK to mail address? Y N

Home Phone_____
OK to call and leave message? Y N

Cell Phone_____
OK to call and leave message? Y N

E-mail address _____
(*only for scheduling purposes*) OK to email? Y N

Emergency contact_____
Name Phone # Relationship

==========

Demographics

Date of birth _____-_____-_____

Gender ___male ___female ___other_____(please specify)

What is your race/ethnicity?_____

What is your country of origin?_____

Relationship status: _____

Sexual orientation: _____

What is your occupation? _____

What is your highest level of education? _____

With whom do you live? _____

What is the main reason for your visit today? (brief)

To what extent are you in crisis today?

Not at all A little Some A lot

How many times would you estimate that you will need to meet with the psychologist? *(circle one)*

1 session 2-5 sessions 6-10 sessions 11-14 sessions 15+ sessions

Do you have concerns about the following:
Circle the number for each statement that applies to you.

1. Academic difficulties
2. Alcohol use/abuse
3. Aging issues
4. Anger management
5. Anxious feelings
6. Choice of major/career
7. Concentration problems
8. Concerns about family
9. Cultural/ethnic/racial issues
10. Dealing with conflict
11. Depression
12. Drug use/abuse
13. Eating/body image issues
14. Friends/social support
15. Guilt/shame
16. Health issues
17. Homesickness
18. Identity issues
19. Impulse control
20. LD/ADD/ADHD
21. Disciplinary/Legal actions
22. Loneliness/isolation
23. Loss of significant other
24. Loss of a loved one
25. Mania/bipolar mood
26. Motivation
27. Panic attacks
28. Parent conflicts
29. Pregnancy
30. Relationship issues
31. Repetitive/intrusive thoughts
32. Schizophrenia/psychotic symptoms
33. Self-confidence/self-esteem issues
34. Self-mutilating behavior
35. Sexual assault/abuse
36. Sexual orientation issues
37. Sexual problems/difficulties
38. Shyness
39. Sleep pattern disturbances
40. Stress
41. Suicidal thoughts
42. Time management/procrastination
43. Trouble saying no/setting limits
44. Non-substance addiction (shopping, gambling, internet, pornography, etc.)
45. Athletic performance issues
46. Obsessive-compulsive behaviors/thoughts

Please list the item numbers that identify your three most important concerns today (Items 1 thru 46)
Most important concern _____
2nd most important concern _____
3rd most important concern _____

Were you referred by someone? ____ yes ____ no
Name_____ Relationship to Person _____

If not referred by someone, how did you learn of this service? _____

Are you currently under a doctor's care? ____ yes ____ no
Doctor's name and area (e.g. psychiatry, OB/GYN, cardiology): _____

Are you currently prescribed medication? ___ yes ____ no
Please list name and purpose of each medication:

Do you have Health Insurance? _____ yes _____ no
If yes, who is your insurer? _____

Have you utilized previous counseling/mental health services? ____ yes ____ no
If yes, please list the nature and time period of the services received.
_____
_____
_____

Please check all that apply
____ A family member or friend attempted suicide.
____ A family member or friend died by suicide.
____ I have felt suicidal today.
____ I have felt suicidal this week.
____ I have felt suicidal in the past month.
____ I have felt suicidal in the past 6 months.
____ I feel hopeless about the future.
____ I vomit, take laxatives, or exercise a great deal to control my calorie intake.
____ There are periods of time when I feel so good or hyper that other people thought I was not my normal self.
____ I have been arrested or had disciplinary action taken for an alcohol or drug related offense.

Do you have any pending court or legal issues? ____ yes ____ no

How may drinks do you typically have on a night out? *(circle one)*

None 1-2 drinks 3-6 drinks 7-10 drinks 10-15 drinks over 15 drinks

Finances

How would you describe your **financial status right now?** (*circle one*)

Always stressful	Often stressful	Sometimes stressful	Rarely stressful	Never stressful

How would you describe your **financial status while growing up?** (*circle one)*

Always stressful	Often stressful	Sometimes stressful	Rarely stressful	Never stressful

Religious or spiritual preference

____ Agnostic	____ Atheist	____ Buddhist	____ Christian
____ Hindu	____ Jewish	____ LDS (Mormon)	____ Muslim
____ No preference	____ Other _____ (please specify)		

To what extent does your religious or spiritual preference play an important role in your life? (*Circle one*)

Very important Important Neutral Unimportant Very unimportant

Please indicate yes or no, how many times and the last time you had each of the following experiences.

	Yes/No	Number of times	The last time
Been hospitalized for mental health concerns			
Felt the need to reduce your alcohol or drug use			
Others have expressed concern about your alcohol or drug use			
Received treatment for drug or alcohol use			
Purposely injured yourself without suicidal intent (e.g., cutting, burning, hair pulling, etc.)			
Seriously considered attempting suicide			
Made a suicide attempt			
Considered causing serious injury to another person			
Intentionally caused serious injury to another person			
Someone had sexual contact with you without your consent (e.g. you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced)			
Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner or authority figure)			
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror			

If you selected “yes” to the previous question, please briefly describe the event(s).

_____
_____
_____
_____