CHARLENE UNDERHILL MILLER, PH.D

Individual, Marital, and Child Psychotherapy
MFC 24690

Client Information Form

General Information

Name_____ Birthdate M/D/Y____/____/____ Age_____

Address_____ City_____ Zip_____

Phone (H) (_____)_____ (W) (_____)_____ (M) (_____)_____

SS# (Last four digits) _____

Occupation_____ Employer_____

Marital Status: Single_____ Married_____ Divorced _____ Widowed _____ Separated_____

Emergency Contact _____ Relationship _____

Address_____ City_____ Zip_____

Phone (_____)_____

How did you hear about our services? _____

May I say who I am if I call your home (Yes____ No____) or work (Yes____ No____)

Insurance Information

Name of Insured _____Relationship to patient _____

Insurance Company _____

Address _____

_____

Policy Number _____ Group Number _____

Will you need a monthly statement to file with your insurance carrier so that you may receive reimbursement for my services? Yes_____ No_____

PO Box 1122 _ Malibu, CA 90265
Phone (310) 576-0883 _ Fax (310) 317-0902
www.underhillmiller.com

Areas of Concerns

What issues/concerns cause you to seek treatment? Please describe._____

_____

_____

Do you have any specific goals with regard to your treatment?_____

_____

_____

Psychotherapy History

Have you had previous therapy/counseling? Yes____ No____

If yes, where? _____ Date_____

_____ Date_____

_____ Date_____

Are you currently taking medication for emotional or mental issues? Yes_____ No_____

If so, please list medication, dosage and prescribing doctor: _____

_____

_____

What was the nature of your presenting problem?_____

Have you ever been hospitalized for mental or emotional problems? Yes_____ No_____

When and for how long?_____

Why were you hospitalized?_____

Name of treating therapist, address, telephone number_____

_____

Medical History

Have you ever been diagnosed with a serious illness? Yes____ No____

If yes, please describe:_____

Do you have any medical conditions that may affect your mental health treatment?_____

_____

Please describe your overall health today. _____

When was your last general medical exam? _____

Please add any other information you believe would be helpful for me to know about. _____

_____

_____

_____

_____

Financial Agreement and Authorization for Treatment of a Minor:

I authorize treatment for my minor child and attest that I am the legal guardian, solely and legally able to obtain treatment for this child, and can produce required documentation.

Signature _____Relationship to minor _____ Date _____

Signature _____Relationship to minor _____ Date _____

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me or my family, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

Signature_____ Date_____