Marni Millet, LCSW, CASAC
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Name_____Email_____

Address_____City_____State _____

Zip_____Cell Phone:_____ Other Phone: _____

Date of Birth_____ Age_____SSN_____

Gender_____Sexual Orientation_____Spirituality _____

Education _____ Profession_____

Employer _____Years employed _____

Marital Status: Single_____Married_____(years) Divorced_____Separated_____Widow(er)_____

Children:Female(s)_____Ages_____Male(s)_____Ages_____ Other _____Ages_____
Are any adopted or foster, please list:

_____

EmergencyContact_____ Relationship_____

Phone _____Do I have your permission to contact this person in case of

emergency?_____

Why are you seeking help today and how may I help you?

_____

How did you hear about my services?_____

Please list at least three strengths you have:
1._____

2._____

3._____

Please list at least three supports you have:

1._____

2._____

3._____

ALLERGIES to medication /food/animals/other_____

_____

Vitamins/Minerals_____

Holistic therapies _____

Meal preferences,Vegan/vegetarian/GF/DF, organic, etc_____

Exercise Regimen_____

Sleep cycle disturbances/sleeping waking times _____

Caffeine and sugar intake _____

MEDICAL/PSYCHIATRIC TREATMENT

Are you currently receiving medical treatment Yes_____No_____Reason_____

_____

Primary care physician _____Phone_____

Address_____

Please list all **prescription medications (**including Medication Assisted Treatment including:

Methadone/Suboxone/Vivitrol, etc) and others for recovery from addiction. _____

_____

Mental Health Treatment History_____

_____

History of TRAUMA, Yes/No. Is there CURRENT /history of abuse in relationship? Yes/No?

History of any type of self harm?_____When _____

Psychiatric hospitalizations?_____When/where?_____

_____

Known Psychiatric Diagnosis_____

Have you ever attempted suicide?_____When?_____

Family history of suicide? _____Resulted in death? _____

Do you currently consume alcohol, Yes/No Drink of choice?_____

Daily/weekly/monthly, how many drinks per occasion to you consume? _____

Do you have a history of problems with drugs/alcohol? Yes/No, Are you in recovery? Y/N.

Do you currently use illicit drugs? Yes/No, list drug(s):_____
How often, the amount used, and route of administration (oral, inhalation, ingestion, IV etc):

_____

Date of last use for alcohol: _____ Drug(s):_____

Current/history treatment for substance use including alcohol? Yes/No, Where/date: _____

_____

_____

Are you pregnant?_____Have you ever overdosed?_____When?_____

Have you ever been revived with Narcan?_____Do have a Narcan kit?_____

Are familiar with 12 step supports?_____ Do you have access to them? _____

Any supports you are involved with at this time or that have previously benefitted you:_____

_____

Patient Signature:_____ Date:_____

Recovery and Support Services :
AA, NA, Al-Anon
Helio Health includes children services
Vera House

Therapists:
Deb Pollack, PhD
Karen Schwarz, LMHC, CASAC
Linda Land, LCSW
Anita Convertino, LCSW

Children's services:
Suzanne Nolan, LCSW
Tanya Gesek, PhD
Helio Health
Hutchings
Liberty Resources

Psychiatric Nurse Practioner:
{Jessie} Zhe Lin, FPMHNP-BC, Includes children services
Psychiatrist:
Dr. Donovan, MD
Dr. Ghaly, MD

Emergency Services for SUD to include Opioid prescribing:
SUNY UPSTATE ER

Emergency Mental Health Crises Services:
CPEP at St Joseph's Hospital
Upstate at Community Hospital

If you need immediate medical assistance, please dial 911.

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

New York State Domestic Violence Hotline: 1-800-942-6906

Crisis Text Line: Text "Got5" to 741-741

TREATMENT and RESIDENTIAL PROVIDERS IN NYS for help with problem Substance Use and Gambling:

OASAS HOPEline 1-877-8-HOPENY