M a r n i M I l l e t, L C S W, C A S A C

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Name____Email__________________________________

Address________________________________City_________________________State______________

Zip________________Phone:_________________________D.O.B.____________________Age______

SSN_____________________________Gender_______________SexualOrientation________________

Race/Region/Clan, etc.,____

Spirituality ________________________ and/or Religion____

Education___________________________________Profession __________________________________

Employer _____________________________________Years employed __________________________

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

Children, names and ages:____

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.____

Do you have any animals, describe:____

Any customs/cultural interests I should know about that are important to you?

____

Please list at least three supports you have:

1.____

2.____

3.____

ALLERGIES to medication /food/animals/chemicals

____

Vitamins/Minerals____

Holistic therapies ____

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

etc_______________________________________ Exercise Regimen__________________________

Sleep cycle disturbances/sleeping waking____

Caffeine and sugar intake

____

MEDICAL/PSYCHIATRIC TREATMENT

Are you currently receiving medical treatment

Yes_______No________Reason____________________

____

Primary care physician Name/Group____

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. History of abuse in relationship? Yes/No, Current?______________

History of any type of self harm?____

Type:____Currently?_________________

_______________________________________Psychiatric hospitalizations?___________________

____

Known Psychiatric Diagnosis____

Have you ever attempted suicide?____________When?__________________________

_____________________________ How?__________________________________

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: ______

____

Client Signature: ____Date: __________

<u>Please see resources tab on my website for supportive information you may find helpful</u>