MEIER CLINICS PATIENT REGISTRATION

PATIENT INFORMATION

Name:____
(Last) (First) (Middle Initial) (Nickname)

Mailing Address:____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Home Phone:____________________ Work Phone:____________________ Ext. #:_______ Cell:____________________

Social Security #:____________________ Sex: ❐M ❐F Birth date:____________________ Age:__________

Marital Status: ❐Single ❐Married ❐Divorced ❐Widowed ❐Other ____________________

Ethnicity: ❐American Indian/Alaskan Native ❐Asian ❐African/American ❐Hispanic ❐White ❐Hawaiian/Pacific Islander ❐Other____________________

GUARANTOR INFORMATION
(Person who is financially responsible if different from patient above.)

Name:____ Birth date:____________________
(Last) (First) (Middle Initial)

Mailing Address:____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Relationship to Patient: ❐Spouse ❐Mother ❐Father ❐Sibling ❐Other (relationship) ____________________

Home Phone:____________________ Cell Phone:____________________ Soc. Sec. #:____________________

INSURANCE INFORMATION

NOTE: Meier Clinics® ONLY files insurance if your provider is contracted with your insurance plan. Complete the following ONLY if we are filing claims for you.

Primary Insurance Co. Name:____ Phone:____________________

Subscriber's Name:____________________ Relationship to Pt: ❐Self ❐Spouse ❐Parent ❐Other____________________

Employer:____ Phone:____________________

Birth date:______________ Member ID #:____________________ Group ID #:____________________

Secondary Insurance Co. Name:____ Phone:____________________

Subscriber's Name:____________________ Relationship to Pt: ❐Self ❐Spouse ❐Parent ❐Other____________________

Employer:____ Phone:____________________

Birth date:______________ Member ID #:____________________ Group ID #:____________________

CONSENTS TO RELEASE INFORMATION

I hereby consent for Meier Clinics to contact my Primary Care Physician or other health care provider as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit unless expressly revoked by me in writing.

Physician Name: ____ Phone #: ____________________

Address: ____

- -

I hereby consent for Meier Clinics to contact the person(s) below as deemed necessary regarding the information indicated. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit or after services have been paid in full unless expressly revoked by me in writing.

Name	Relationship	Daytime Phone #	Evening Phone #	OK to leave message	Financial Info.	Medical Info.	Other (Specify)
				❑	❑	❑	
				❑	❑	❑	
				❑	❑	❑	
	Pastor			❑	❑	❑	

CONSENT FOR CONTACT

By providing an e-mail below, I hereby consent to the following: Contact by Meier Clinics (MC) via e-mail communication at the personal address below. I am 18 years old or older, or the e-mail is that of a parent/legal guardian. E-mails may be viewed by unintended persons as e-mails are not sent by way of encryption. E-mail communication may be seen, received and/or responded to by any MC staff. E-mail is not intended for clinical purposes or as a replacement to therapy but may be used as a simple adjunct to therapy or for administrative purposes (i.e., billing, appointments, satisfaction surveys, donor opportunities, events, etc.). I release and hold harmless MC and MC staff for any claim(s) I may have, past, present and future, arising from the use of e-mail. This consent will remain in force until I provide written revocation to MC.

E-mail Address: ____

Appointment Reminders: ❑ text me at ______________________ **OR** ❑ call me at ______________________________

ACKNOWLEDGEMENTS

By signing below, I acknowledge the following:

- I have been offered the "Notice of Privacy Policies and Clients Rights."
- I have consented to treatment provided by Meier Clinics and its employees or designees (caregivers). I understand Meier Clinics serves as a training ground for mental health professionals and that I may be seen by an intern who will provide care to me under the supervision of a licensed professional. I authorize the services deemed necessary or advisable by my caregivers to address my needs.
- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Meier Clinics. I authorize Meier Clinics to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Meier Clinics may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
- I authorize and request my insurance plan(if applicable) pay directly to Meier Clinics the amount due for services rendered to the patient, myself, or others covered by the above insurance plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulations.
- I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform Meier Clinics in a timely manner of any changes to my insurance coverage, I understand that I may need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
- I understand that my patient records are the property of Meier Clinics and shall be treated as confidential; that Meier Clinics will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the State where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using Meier Clinics "Authorization for Use and Disclosure of Protected Health Information" form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgement.
- I acknowledge that if I need to cancel or reschedule an appointment I will provide a minimum of one business day's notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
- I attest that I am coming strictly for counseling needs, not for any type of litigation purposes. If in the course of my care, I become involved in litigation and need Meier Clinics to provide any type of report, testimony or other litigation required services, I understand I am fully responsible for any fees for these services and that these fees are payable in full and in advance of services.
- I acknowledge that Meier Clinics is not a 24/7 care facility and that I am responsible for seeking care at my nearest emergency center or through another provider of choice when my Meier Clinics caregiver is not available.
- I certify that all the information I have provided above is true and correct.

Patient Signature: ______________________________________ Date: ____________________

Guarantor's Signature (if not patient): ____________________________ Date: ____________________

Patient/Guardian Name (please print if applicable): ____

PLEASE COMPLETE THIS SECTION ONLY IF APPLICABLE

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

I certify that I am the ❒ father, ❒ mother, ❒ legal guardian and have legal custody of the above named patient. I, hereby, give my authorization and consent for the patient to receive outpatient assessment/treatment from ____.
I understand it is the policy of Meier Clinics that the parent/guardian bringing the patient for treatment is responsible for payment at the time services are rendered. I will be responsible for payment of the patient's treatment regardless of any financial arrangement for payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party. I understand that Meier Clinics assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient's medical care.

Parent/Guardian Name (please print): ____

Parent/Guardian Signature: ______________________________________ Date: ____________________

TO BE COMPLETED ONLY BY STAFF Provider:______________ Appt: ____________________ Acct. #:______________

Staff Witness: ______________________Comments:____

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One of the most trusted names in Christian Counseling

Name_______________________________________ Date_____________________
Age: _________ Marital Status: ______________ Employment Status: ___________________
Date Symptoms Began: ___________________ Date Symptoms Worsened: _________________
What is your goal for seeking counseling at this time in your life? __________________________
____
____

SYMPTOM CHECKLIST

☐ Depressed or Sad Mood
☐ Irritability/Short-tempered
☐ Lack of Motivation/Drive
☐ Poor Concentration
☐ Can't sleep well
☐ Appetite/weight changes
☐ Loss of pleasure in activities
☐ Diminished self-esteem
☐ Hopeless/Helpless
☐ Decreased Energy/fatigue
☐ Excessive guilt or worry
☐ Crying Spells
☐ Decreased sex drive
☐ Intense fear of being fat

☐ Spending sprees
☐ Special Abilities
☐ Increased self-esteem
☐ Decreased need for sleep
☐ Lots of great ideas to get out
☐ Racing thoughts/can't keep up
☐ Increased energy/hyperactive
☐ Increased sex drive
☐ Making lots of plans/schemes
☐ Rapid speech
☐ Nonstop talking/can't interrupt
☐ Day-to-Day mood swings

☐ Suspiciousness/Paranoia
☐ Hallucinations (see/hear things)
☐ Unusual facial expressions
☐ Strange posture/gestures
☐ Disorganized thoughts
☐ Confusion
☐ Bizarre Behaviors
☐ Unusual or unwanted thoughts
☐ Constantly washes hands

☐ Anxiety about everything
☐ Intense episodes of fear
☐ Fear of Going crazy/losing control
☐ Chills/Hot flashes
☐ Abdominal distress/nausea
☐ Chest discomfort/choking
☐ Dizziness
☐ Numbness/tingling
☐ Feeling jumpy/on edge/easily startled
☐ Constantly Alert/Vigilant
☐ Nightmares/reliving trauma
☐ Avoiding of stressors/stimulus
☐ Heart racing/palpitations
☐ Sweating
☐ Trembling
☐ Shortness of Breath
☐ "Lump in Throat"/can't swallow
☐ Intense anxiety, fear, or panic
☐ Unable to leave home

☐ Counts things constantly
☐ Impaired intellect/thinking
☐ Language/speech difficulties
☐ Impulsive/poor judgment
☐ Unusual sleep pattern
☐ Disorganized/Confused
☐ Poor Memory

SUBSTANCE ABUSE
☐ Amphetamines/Stimulants
☐ Cocaine/Crack
☐ Marijuana/Cannabis
☐ Alcohol
☐ Sedative/Hypnotics
☐ Opiates/Narcotic pain pills/Heroin

Suicidal thoughts? o Yes o No
☐ passing thoughts/no intent
☐ persistent thoughts
☐ current plans/definite intent
☐ recent attempt
☐ past attempts

☐ Pulling hair out
☐ Anger/Emotional outburst
☐ Binge Eating/Purging
☐ Uncontrolled Gambling
☐ Stealing or Lying
☐ Ritualized behaviors/obsessions

☐ Attention/concentration issues
☐ Impulsive/can't wait turn
☐ Hyperactive/restless
☐ Can't perform at work/school
☐ Aggressive/Assaultive
☐ Self-mutilation/Self-harm
☐ Sleeping all the time
☐ Staring spells
☐ Chronic Pain
☐ Self-induced vomiting
☐ Constant agitation
☐ Intense fear of rejection
☐ Legal Troubles
☐ Unexplained body complaints

Personal Past Psychiatric History: ☐ Counseling ☐ Psychiatrist ☐ Hospitalization ☐ Suicidal Attempts
Past or Current Medical Issues (thyroid/high blood pressure/etc) ____________________________
____

Please List your top 3 symptoms: ________________ ________________ ________________

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DAY PROGRAM
HEALTH SCREENING QUESTIONNAIRE

Name: ______________________________ Record #: ____________________

Date: ____________________ Date of Birth: ______________ *Your Age **Today:*** _________

Please complete the following questions and give dates (month/year) when applicable.

1) When did you last have a complete physical exam? ______________________________

2) Do you have problems with any of the following body systems: (check all that apply)
❒ Nose/Throat/Sinuses
❒ Skin, Hair, Nails
❒ Teeth
❒ Urinary (Kidney) system
❒ Respiratory/Breathing System
❒ Heart/Blood Vessels/Circulation
❒ Nervous System (head, spine, brain, nerves)
❒ Digestive System (stomach, intestine, etc)
❒ Breasts
❒ Muscles, Bones, Joints
❒ Eyes/Ears
❒ Male Genital System
❒ Female Genital System
❒ Glands/Hormones
❒ Abnormal Blood Tests

3) Have you had any serious medical problems in the past? ❒ yes ❒ no
If yes, explain: ____
____

4) Has your biological mother or father had any disorder or disease that was serious or you were told could be inherited? ❒ yes ❒ no If yes, explain: ______________________________
____

5) Have you ever used any of the drugs listed below? ❒ yes ❒ no If yes, give the date of the last time you remember using them.
marijuana ____________ "uppers"____________ cocaine__________ alcohol__________
hallucinogens __________ "downers" __________ other: ________________________

6) In the past or currently, are you addicted to any prescription drugs? ❒ yes ❒ no
If yes, explain: ____

7) Do you have trouble with sleeping too much or too little? ❒ yes ❒ no If yes, explain: ____________
____

8) Do you binge, purge, use laxatives, or have any other problem with food habits? ❒ yes ❒ no
If yes, explain: ____

9) Are you allergic to any medications? ❒ yes ❒ no If yes, list: ________________________
____

10) At any time in the past have you received treatment for sexually transmitted diseases? ❒ yes ❒ no
If yes, when and what disease(s): ______________________________________

11) Are you currently pregnant? ❒ yes ❒ no When was your last menstrual period? ______________

12) Have you been involved in any behavior that would place you at risk of contacting a Sexually Transmitted Disease (STD)? ❒ yes ❒ no If yes, have you been tested for STD's or AIDS? ❒ yes ❒ no
If yes, when were you tested and what were the results? ______________________________
____

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Patient Name: ____

FOR STAFF USE ONLY

Temp________ Pulse ________ Resp.________ BP___________ Ht.________ Wt.________

EXPLANATIONS/CONCLUSIONS:

____

____

RECOMMENDATIONS:

____ History and Physical was completed (date)___________________________ and ordered from

____ Date Received:_________________________

____ History and Physical Recommended (see Consultation sheet)

Scheduled: ____

____ Nutritional Assessment Recommended

Scheduled: ____

____ Chemical Dependency Consultation

Date SASSI given: ___________________________________

____ Laboratory Tests: (circle all that apply) SMAC, CBC, Thy. Profile, TSH, U.A.

Drug & Alcohol Screen: ____

Date Scheduled: _________________________________ Date Reported: ________________________

____ Other Lab Tests or Exams: ____

____

____ EKG (*Recommended if patient over 40 years old*)

____ _____________________________________

Registered Nurse Date

____ _____________________________________

Psychiatrist Date

CARF Day Program Health Screening Questionnaire Rev 8/12/04 & 1/24/05

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Name ______________________________ Date ________________________ ID # ______________

PSYCHIATRIC MEDICINES

ANTI-DEPRESSANTS	MOOD STABILIZERS	ANTI-ANXIETY	Major Tranquilizers	ADHD	SLEEP	PAIN
Anafranil	Carbatrol	Ativan (Lorazepam)	Abilify	Adderall	Ambien	Amerge
Aplenzin	Celontin	Buspar	Clozaril	Clonidine	Ambien CR	Anaprox
Brintellix	Depakote	Klonopin (Clonazepam)	Fanapt	Concerta	Dalmane	Axert
Celexa	Dilantin	Librium	Geodon	Cylert	Doxepin	Butalbital
Cymbalta	Felbatol	Moban	Haldol	Daytrana	Lunesta	Codeine
Desyrel	Gabitril	Neurontin	Invega	Dexadrine	Restoril	Darvocet
Effexor	Keppra	Restoril	Latuda	Focalin	Rozerem	Esgic
Elavil	Lamictal	Serax	Loxitane	Intuniv	Silenor	Fiorcet
Emsam	Lithium	Tranxene	Mellaril	Metadate	Sonata	Frova
Fetzima	Lyrica	Valium (Diazepam)	Navane	Methylin	Trazadone	Hydrocodone
Lexapro	Myosline	Vistaril	Prolixin	Nuvigil		Imitrex
Luvox	Phenobarbital	Xanax	Risperdal	Provigil		Lorcet
Nardil	Tegretol		Saphris	Ritalin		Lortab
Norpramin	Topamax		Seroquel	Strattera		Midrin
Pamelor	Trileptal		Stelazine	Tenex		Norco
Parnate	Zarontin		Thorazine	Vyvanse		Percocet
Paxil	Zonegran		Trilafon			Phrenilin
Pristiq			Zyprexa			Stadol
Prozac						Ultracet
Remeron				**ALCOHOL/DRUG CRAVINGS**		Ultram
Serzone						Vicodin
Sinequan				Campral		Zomig
Viibyrd				Naltrexone		Zydone
Vivacti		**PSUEDOBULBAR AFFECT(PBA)**		Neurontin		
Wellbutrin		Nuedexta		Suboxone		
Zoloft						

Place a check mark next to any medications you think you may have taken in the past even if it was for a very short time. Then, off to the side please write a one to two word description or phrase describing your experience with the medicine (e.g. "good" "bad" "great" "made me dizzy" "made me sleepy" etc.). Knowing how you responded on certain medication in the past will help us in your treatment.

MEDICATIONS: *Please list medications you are currently taking (psychiatric or other)*

____

____

List any Medications you are allergic to:

____

Patient Name		Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
							Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?							
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?							
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?							
10. How often do you misplace or have difficulty finding things at home or at work?							
11. How often are you distracted by activity or noise around you?							
12. How often do you leave your seat in meeting or other situations in which you are expected to remain seated?							
13. How often do you feel restless or fidgety?							
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?							
15. How often do you find yourself talking too much when you are in social situations?							
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?							
17. How often do you have difficulty waiting your turn in situations when turn taking is required?							
18. How often do you interrupt others when they are busy?							
							Part B

PSYCHOSOCIAL ASSESSMENT
Age 16 and Above

Name: ______________________________ Record# ______________

Age: _____ DOB: ____________ Sex: _____ Clinician: ______________________________

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment

Present Problem/Stressors: *Please check all that apply:*

- ❑ Marital issues ❑ Health issues ❑ Job issues ❑ Financial issues
- ❑ Parent/child issues ❑ Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
- ❑ Other ______________________________

Symptoms: *Please check all that apply:*

- ❑ Change in sleep pattern ❑ Depressed mood ❑ Mood swings
- ❑ Decreased energy ❑ Decreased interest or pleasure ❑ Anger problems
- ❑ Decreased concentration ❑ Change in appetite ❑ Thoughts of death
- ❑ Decreased motivation ❑ Anxiety/Worry/Panic
- ❑ Other ______________________________

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? ❑ yes ❑ no

If yes, how? ______________________________

Is there a history of suicide in your nuclear and/or extended family? ❑ yes ❑ no

Have you ever inflicted burns or wounds on yourself? ❑ yes ❑ no

Are you presently suicidal or homicidal? ❑ yes ❑ no

Are there any other risk-taking behaviors that you engage in? ❑ yes ❑ no

If yes, please explain ______________________________

What event(s) in the recent past has prompted you to seek counseling? ______________________________

____

____

Describe additional problems you are experiencing. ______________________________

____

____

____

When did these problems develop? ______________________________

____

____

Check any recent losses you have experienced.

- ❑ Family ❑ Health ❑ Disruption of lifestyle ❑ Job ❑ Significant other
- ❑ Other ______________________________

List your strengths and weaknesses.

Strengths	Weaknesses

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Psychiatric History

Have you ever had any previous outpatient counseling? ❑ yes ❑ no If yes, please complete information below.

Place	Length of Time	Date(s)

Have you ever been admitted to the hospital for mental health or addiction issues? ❑ yes ❑ no

Place: ______________________________ Dates: ______________________________

Name of current doctor and/or therapist: ______________________________

Have you ever received a psychiatric diagnosis? ❑ yes ❑ no If yes, please explain. ______________

____

Do you feel medications you have been on, past or present, have been effective? ❑ yes ❑ no

Please explain: ______________________________

List all medications you have taken *in the past* for anxiety, depression, and/or sleep. ______________

____

Medical Information

How would you describe your current condition of health? ______________________________

Do you have any disabilities and/or disorders? ❑ yes ❑ no If yes, explain. ______________

____

Explain any special adjustments needed for the disability or disorder: ______________________

____

Are you currently on any medication? ❑ yes ❑ no If yes, please complete the information below.

Name of Medication	Dosage/Frequency	Prescribing Physician

Are you allergic to any medications or have you ever had an adverse reaction to medication? ❑ yes ❑ no

If yes, please list: ______________________________

Has it been more than a year since your last physical exam, including blood tests? ❑ yes ❑ no

Have you ever had an abortion? ❑ yes ❑ no Males: Has a child of yours ever been aborted? ❑ yes ❑ no

Do you have allergies? ❑ yes ❑ no If yes, explain. ______________________________

List any previous health problems, operative procedures, and medical hospitalizations.

Problem	Dates	Treatment

Substance Use History

Describe your current usage, or usage within the past year (includes alcohol, any illegal drugs, caffeine and tobacco).

Substance	Amount	Frequency	Age of 1st Use	Age regular use started	Last use

Have you experienced a recent increase in the use of alcohol and/or other substances? ❑ yes ❑ no

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Do you, your family, or your friends see your current usage as a problem? ❑ yes ❑ no If yes, when did it become problematic? ____________________

Please describe any previous experience with drugs or alcohol. ____________________

Describe any significant family history of substance abuse. ____________________

____

____

Nutrition

Do you feel you have balanced, healthy eating patterns? ❑ yes ❑ no

Do you have a lot of concerns about your weight and shape? ❑ yes ❑ no

Do you often eat out of depression, boredom, anger? ❑ yes ❑ no

Do you ever binge eat or fear losing control of your eating? ❑ yes ❑ no

Do you ever self-induce vomiting? ❑ yes ❑ no

How do you feel about eating with others in a group? ____________________

Do you use laxatives, diuretics (water pills), or diet medications to control your weight? ❑ yes ❑ no

Do you or others believe you exercise excessively? ❑ yes ❑ no

Legal History Please explain all that apply.

Charges as a minor: ____________________

Charges presently: ____________________

Arrests (How many): ____________________

Incarcerations (How many): ____________________

Parole: ____________________

Convictions (How many): ____________________

Probation: ____________________

Bankruptcy: ____________________

Civil Suits: ____________________

Child Custody Problems: ____________________

Developmental History

List members of your family of origin and comment on how you got along with each one.

Name	Relationship	Comment

What was your birth order? I was the _____ of _____ children. Who primarily raised you? ____________

How would you describe your childhood? ❑ Traumatic ❑ Painful ❑ Uneventful ❑ Good ❑ Happy

What were you like as a child (include friends, school, hobbies, and personality)? ____________________

____

____

____

Did you have any unusual or traumatic experiences as a child?

Date	Age	Event

Have you ever been the recipient of unwanted sexual acts? ❑ yes ❑ no

If yes, please explain: ____________________

Have you ever been the victim of abuse, neglect, or violence? ❑ yes ❑ no

If yes, please explain: ____________________

Have you ever been the perpetrator of abuse, neglect, or violence towards another person? ❑ yes ❑ no

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If yes, please explain: ____________________

____

____

What is your sexual orientation? ❑ Heterosexual ❑ Homosexual ❑ Bisexual

Living Arrangements

❑ Satisfactory? ❑ Unsatisfactory?

Where do you currently live? ____________________ How long there? __________

With whom are you living? ____________________

Describe your current relationships with family members. ____________________

____

____

____

Social Relationships/Support System

Who can you count on for support? *Check as many as apply.*

❑Parents ❑Spouse ❑Siblings ❑Extended Family ❑Employer ❑Church ❑Pastor ❑Co-worker
❑Neighbor(s) ❑Close Friend ❑Self-help Group ❑Community Services ❑Therapist ❑Medical Doctor

List close friends, outside of family, if any. ____________________

What are your hobbies or leisure activities? ____________________

Marital History (if applicable)

When were you married? __________ Name and age of spouse. ____________________

Previous marriage(s)? ❑ yes ❑ no If yes, date of divorce(s). ____________________

How many children from above marriage(s)? ____________________

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

____

____

____

List names and ages of children. How do you get along with each one?

Name	Age	Comment

Financial Situation

Describe briefly your financial situation. ____________________

____

____

____

Religious/Cultural Factors

What is your religious background? ____________________

Describe the religious atmosphere in your home (past or present). ____________________

____

____

____

____

____

Do you currently attend church, synagogue, mosque, or other religious services? ❑ yes ❑ no

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What does God seem like to you? ____________________

Describe your relationship with God. ____________________

What do you consider to be the role of God in your recovery? ____________________

Please list any issues (positive or negative) which are important or may have affected you in regard to religion or ethnic/cultural background. ____________________

Educational History

What was school like for you? ____________________

Highest grade level achieved. __________ What type of grades did you make? ____________________

Are you currently in school? ❑ yes ❑ no If yes, what grade level? ____________________

Work Adjustment History

Describe your current job/career. ____________________

Would you enjoy doing this job on a long-term basis? ____________________

How do you deal with authority figures? ____________________

Describe your relationship with co-workers. ____________________

Describe your job performance. ____________________

Have you ever been fired or laid-off? ❑ yes ❑ no If yes, explain. ____________________

How many jobs have you held within the previous five years? ____________________

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Military History
List branch, dates, and duties.

____
____
____

Family
Would it be beneficial for any member(s) of your family/legal guardian to be involved in your treatment?
❑ yes ❑ no If yes, explain who and why. ______________________________
____
____
____

May we contact any of the persons you have mentioned above for their input and involvement in your care?
❑ yes Contact Information: ______________________________
❑ no

What is your family/legal guardian's perception of your difficulties? ______________________________
____
____
____
____

Miscellaneous
Are there any other things that would be helpful for us to know about you? ______________________________
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With your permission, is there anyone else that would be appropriate to contact in regard to your care?
❑ yes Name and phone number. ______________________________
❑ no

How were you referred to Meier Clinics®? ______________________________

Is there anyone that we are legally required to notify in regard to your care? ❑ yes ❑ no
If yes, please give us the necessary information to contact them. ______________________________
____

Is there a need for assistive technology in your treatment? ❑ yes ❑ no If yes, what is that need? __________
____
____

What would you like to accomplish during your treatment with Meier Clinics®? ______________________________
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____

Client Signature: ______________________________ Date: ______________

Read and Reviewed by ______________________________ Date: ______________
(Clinician)

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