Kathryn B. Miller, PhD

Licensed Psychologist

Intake Questionnaire

Name: ____

What has prompted you to seek treatment now? ______________________________

What are your goals for treatment?

1. ____

2. ____

3. ____

Have you had any prior psychological treatment? ☐ No ☐ Yes (If yes, please complete:)

Age/ Date	Provider/Clinic	Reason for treatment.	Was it helpful?

Please check any of the following significant stressful life events that have occurred in the past year and briefly describe:

☐ Arguments with family/friends/ neighbors: ______________________

☐ Friendship problems: ______________________

☐ Death of a family member or significant person: ______________________

☐ Move/ Change of residence: ______________________

☐ Trauma: ______________________

☐ Break up/separation/divorce: ______________________

☐ Serious Illness of a family member: ______________________

☐ Unemployment: ______________________

☐ Financial stress: ______________________

☐ Other: ______________________

Do you have any medical problems or diagnoses? If yes, please describe.

____

____

____

____

Form continued on the next page

5101 Olson Memorial Hwy, Suite 4004, Golden Valley, MN 55422 T: 763.595.7294 ext. 114 F: 763.595.7293

Do you take any medications? ☐ No ☐ Yes (If yes, please complete:)

Name of medication What is it used for? Dosage Age/date started taking

____

____

____

____

Have you ever been hospitalized? ☐ No ☐ Yes Describe ______________________________

Have you ever had surgery? ☐ No ☐ Yes Describe ______________________________

Please make any additional comments that you think would be helpful:

____

____

____

____

Thank you for your time and effort in completing this form.