Miles Psychological Services, LLC
606 25th Avenue South #105, St. Cloud, MN 56301
320.247.4737 (office) - 320.365.0080 (fax) - www.MilesPsychology.com

CLIENT REGISTRATION

Name: _____ Birthdate: _____
First Middle Last

SSN: _____-_____-_____ Age: _____

Address: _____

City / State / Zipcode: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Do you accept: ☐ Text Messages ☐ Emails ***Preferred Contact***: ☐ Home ☐ Cell ☐ Email

Parent/Guardian Name (if under 18): _____ Phone: _____

Others in Family (spouse, children, and/or anyone you live with):

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Employer: _____ Occupation: _____

Primary Insurance:_____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

Referred By: _____ Primary Care Physician: _____

The undersigned agrees to pay for all professional services rendered and gives consent for the release of any necessary information to your insurance company and third-parties for billing purposes.

_____ Date: _____
Signature

Section A: Reason for Your Visit

Please briefly describe your presenting concern(s) in your own words:

_____

_____

_____

_____

Please Check *All* That Apply & *Circle* your greatest concern:

Difficulty With:	Now	Past	Difficulty With:	Now	Past	Difficulty With:	Now	Past
Anxiety			People in General			Nausea		
Depression			Parents			Dizziness		
Mood Changes			Children			Fainting		
Anger / Temper			Marriage / Partnership			Abdominal Distress		
Panic			Friend(s)			Diarrhea		
Fears			Co-worker			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain		
Trusting Others			Domestic Violence			Pain in Joints		
Communicating with Others			Thoughts of Hurting Someone			Chills or Hot Flashes		
Drugs			Hurting Self			Impulsiveness		
Alcohol			Thoughts of Suicide			Fidgets Frequently		
Caffeine			Sleeping Too Much			Often Making Careless Mistakes		
Frequent Vomiting			Sleeping Too Little			Easily Distracted		
Eating Problems			Falling Asleep			Paying Attention		
Weight Gain			Waking Too Early			Completing Tasks		
Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Allergies		

Section B: Medical History

Please explain any significant medical problems, symptoms, or illnesses:

_____

_____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Prescribing Doctor

Do you smoke or use tobacco? YES NO If yes, how much per day? _____

Do you consume caffeine? YES NO If yes, how much per day? _____

Do you drink alcohol? YES NO If yes, how much per day/week? _____

Previous Hospitalizations (approximate dates and reasons): _____

_____

Have you ever talked with a psychiatrist, psychologist, or any other mental health worker? YES NO

(please list approximate dates and reasons)

_____

_____

_____

Family History of (check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression	
Legal Trouble			Sexual Abuse			Anxiety	
Domestic Violence			Hyperactivity			Psychiatric Hospitalization	
Suicide			Learning Disabilities			"Nervous Breakdown"	

Section C: Additional Information

Is there any additional information that might be of importance at this time?