# *Confidential Adult Patient Background Information*

**Revel Miller, Ph.D.**

Psychologist

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## Instructions:

Your responses in this questionnaire are confidential. The questions address a number of personal issues about your life. Please be as forthright as you can be in your anwers. I will not share this questionnaire or your responses with any of your friends, partners, family members, doctors or attorneys without your permission.

This is a very thorough assessment of your background. Completing this questionnaire on your own will save you time and money. It will result in you and me gaining a deeper understanding about your current situation and developing an effective treatment plan.

There are a lot of questions here. Please stick with it, knowing that all this information will be used to your advantage. In order to help you, I need to know who you are, what you have experienced, and your past and current situations.

If you have any questions, please write them in the margins or ask me when we meet face-to-face. You can complete the final unanswered questions when we are together.

**Please use a blue ink pen, write clearly, and check off boxes with large visible marks.**

**If something does not apply to you, simply leave it blank.**

If you need more room to write a response, please continue writing on the backside of the page. If you have additional information or concerns that you want to share with me, please write your statements in the lined area at the end of the questionnaire.

Just keep moving quickly and spontaneously through these questions to the end where I ask you to sign and date this document. Please return your completed questionnaire to me at our next meeting.

Thank you,

Revel Miller, Ph.D.



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Your Name: _____ Date: _____/____/_____

## **Current Symptom Checklist** *(Check all current symptoms and concerns)*

| | | |
|---|---|---|
| □ sad/depressed mood | □ health concerns | □ family conflict |
| □ appetite disturbance | □ obesity | □ parent-child conflict |
| □ recent weight gain or loss | □ anxiety/panic attacks | □ family violence |
| □ sleep disturbance | □ compulsive behaviors | □ family abuse |
| □ fatigue/low energy | □ obsessive ideas | □ parenting problems/stress |
| □ irritability | □ life/work/school stress | □ marital dissatisfaction |
| □ poor concentration | □ relationship stress | □ marital conflict |
| □ mood swings | □ panic attacks | □ marital separation |
| □ elevated mood/euphoria | □ PTSD/flashbacks | □ marital divorce |
| □ agitation | □ guilt | □ love frustrations |
| □ anger outbursts | □ shame | □ love disappointment |
| □ aggressive behavior | □ paranoid ideas | □ poor love relationships |
| □ intimidating/violent acts | □ sexual concerns | □ love relationship loss |
| □ hyperactivity | □ purposelessness | □ aging issues |
| □ emotionality | □ loss of meaning | □ physical complaints |
| □ challenging life transition | □ poor self-esteem | □ chronic medical illness |
| □ grief/mourning | □ poor self-confidence | □ life threatening disease |
| □ hopelessness | □ loneliness | □ stress from illness/disease |
| □ post-traumatic stress | □ social isolation | □ caregiver stress |
| □ suicidal ideas/urges | □ social discomfort | □ financial stress/worries |
| □ suicidal plan | □ learning disability | □ smoke cigarettes |
| □ past suicidal attempts | □ physical disability | □ drug abuse |
| □ eating problems | □ dissociation | □ alcohol abuse |
| □ women's issues | □ emotional trauma | □ employment problems |
| □ men's issues | □ physical abuse | □ legal problems |
| □ sexual identity issues | □ sexual abuse | □ other:_____ |
| □ self-criticism/esteem | □ cutting/burning self | |
| □ negative inner voice | □ delusions/unrealistic ideas | _____ |
| □ binging/purging | □ hallucinations | |
| □ laxative/diuretic abuse | | _____ |



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## Emotional/Psychological History

Describe your current mental/emotional/psychological health:

□ Great □ Satisfactory □ Unsatisfactory □ Poor

Past ***Out***patient Psychotherapy? □No □Yes Provide information on past 2 therapists below.

1. Name of previous therapist_____ Phone #:_____

Address:_____

Seen from:___/_____ to ___/_____ Approximate number of sessions?_____

Reason seen:_____

Final outcome:_____

Helpful? □Yes □No Your experience with therapist: □ positive □ neutral □ limited □ negative

2. Name of previous therapist_____ Phone #:_____

Address:_____

Seen from:___/_____ to ___/_____ Approximate number of sessions?_____

Reason seen:_____

Final outcome:_____

Helpful? □No □Yes Your experience with therapist: □ positive □ neutral □ limited □ negative

Past ***In***patient Treatment for psychiatric, emotional or substance use issue? □ No □ Yes

Name and location of most recent facility:_____

From:___/___/____ to___/___/____ Helpful? □ No □ Yes Length of stay?____ Days

Have you attempted suicide? □ No □ Yes If Yes, how many attempts?_____

What year(s):_____ Your age(s):_____ Have you purposefully injured yourself WITHOUT a suicidal attempt? □ No □ Yes How?_____



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Psychological Health:
List any significant life changes, challenges or stressors over the past 6 months:_____

_____

How would you rate your stress level over the past month? □ low □ medium □ high

If you experience stress, what causes your stress? _____

_____

What are the symptoms of your stress?_____

Do you experience sadness, depression or grief? □ No □ Yes If Yes, what causes your depression? _____

_____

For how long have you been depressed?_____

Do you experience anxiety, fear or panic attacks? □ No □ Yes If Yes, what causes your anxiety?_____

For how long have you felt this anxiety?_____

How would you rate your sleep pattern? □ Excellent □ Satisfactory □ Unsatisfactory □ Poor

If you struggle to sleep well, which type(s) of problem(s) are you suffering with?

□ Hard to fall asleep □ Wake up in the night □ Wake up early and can't get back to sleep

□ Nightmares

How would you rate your recent body weight? □ Stable □ Losses □ Gains

If you have loses or gains in weight, how many pounds in the past month?_____

Do you consider your weight to be: □ Under-weight □ Normal □ Over-weight □ Obese

If you have any eating problems, describe them here:_____

_____

If you have a weight problem, describe it here:_____

_____

List your personal strengths here:_____

_____

List your personal weaknesses here:_____

_____



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Has any family member had ***in***patient treatment for a psychiatric, emotional or substance use issue? □ No □ Yes

If yes, who and why:_____

Add any additional information here:_____

_____

_____

## Marital/Relationship History

Current Marital Status:

| | | |
|---|---|---|
| □ single, never married<br>□ engaged for ____months<br>□ married for ____ years<br>□ live together for ____ years | □ divorced: date(s) _____<br>□ separated for ____ months<br>□ separation date _____<br>□ in divorce process now<br>□ date divorce started _____ | □ # prior engagements _____<br>□ # prior marriages (self) ___<br>□ # marriages (partner) ____ |

If married or in a relationship now, name of spouse/person:_____

Your Previous Married Last Name:_____ Maiden Name:_____

Intimate/Romantic Relationship(s):

□ Never been in a serious relationship □ Not currently in a serious relationship □ Dating now

□ Many attempts and losses □ Currently in serious relationship for _____ years

Describe the positive or enhancing qualities that you bring into your love relationships:_____

_____

Describe the negative or destructive qualities that you bring into your love relationships:_____

_____



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Current Relationship Satisfaction:

| | | |
|---|---|---|
| □ very satisfied | □ somewhat satisfied | □ very dissatisfied |
| □ satisfied | □ dissatisfied | □ ready to separate |

Do you have some significant secrets about your life that you have never revealed to your spouse/partner? □ Yes □ No If Yes, why haven't you disclosed them?_____

_____

Have you had an affair(s) during your marital/committed relationship(s)? □ Yes □ No

Are you currently having an affair in your current marital/committed relationship? □ Yes □ No

Is it challenging to be honest, communicative and reliable with your partner(s): □ Yes □ No

Briefly describe any significant issues or problems in ***intimate*** relationships:_____

_____

_____

## Your Children

Biological Children: Total Number:_____ Number Biological Fathers?_____

| Names of Children | Age | Date of Birth | Gender | Living where? | How often seen? |
|---|---|---|---|---|---|
| _____ | ____ | _____ | M or F | _____ | _____ |
| _____ | ____ | _____ | M or F | _____ | _____ |
| _____ | ____ | _____ | M or F | _____ | _____ |
| _____ | ____ | _____ | M or F | _____ | _____ |

Any pregnancy or birth complications? □No □ Yes With what child?_____

Step-Children: Number:_____

| Names of Children | Age | Date of Birth | Gender | Living where? | How often seen? |
|---|---|---|---|---|---|
| _____ | ____ | _____ | M or F | _____ | _____ |
| _____ | ____ | _____ | M or F | _____ | _____ |
| _____ | ____ | _____ | M or F | _____ | _____ |
| _____ | ____ | _____ | M or F | _____ | _____ |



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Any step-parenting problems? □No □ Yes With what child?_____

Children with problems:

Name of Child Describe Problem(s)

_____ _____

_____ _____

_____ _____

_____ _____

Name(s) of children most proud of:_____

Names of children who live in Santa Barbara County:_____

Names of your children who now have their own children?_____

Number of grand children?_____

Others who live in your household:

Name Relationship Reason for Living with You

_____ _____ _____

_____ _____ _____

## Parenting History

How did you learn about child rearing, discipline, parenting and needs of children?_____

_____

How do you feel about yourself as a parent?_____

_____

What are your regrets about your parenting?_____

_____



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## Sexual History

Your current sexual desire and appetite is: □ high □moderate □ low □ non-existent

Your past sexual history includes:

| | | |
|---|---|---|
| □ heterosexual orientation<br>□ homosexual orientation<br>□ bisexual orientation | □ currently sexually active<br>□ currently sexually satisfied<br>□ sexually dissatisfied | □ history of promiscuity<br>□ history of unsafe sex<br>□ history of sexual problems |

Your earliest sexual experiences were: □ pleasurable □ unsatisfying □ painful □ frightening

Regarding your current sexual experiences, you often feel:

| | | |
|---|---|---|
| □ pleasure, love & enjoyment<br>□ comfort, relaxation & relief<br>□ excited, elated & desired | □ inhibited & undesirable<br>□ disgusted & fearful<br>□ anxious & avoidant | □ addicted & driven<br>□ physical pain & discomfort<br>□ disappointed & unattractive |

In the past, you were sexually: □ abused □ raped □ criticized □ controlled □ embarrassed

When you look at your body, you feel: □ proud □ satisfied □ dissatisfied □ embarrassed

My concerns about my sexuality, appearance and sexual behavior include:_____

_____

## Family Background & History

| | Present Entire Childhood | Present Part of Childhood | Not Present |
|---|---|---|---|
| Mother | □ | □ | □ |
| Father | □ | □ | □ |
| Step-Mother | □ | □ | □ |
| Step-Father | □ | □ | □ |
| Brother(s) | □ | □ | □ |
| Sister(s) | □ | □ | □ |
| Half/Step Brother(s) | □ | □ | □ |



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| | | | |
|---|---|---|---|
| Half/Step Sister(s) | □ | □ | □ |
| Grand Mother | □ | □ | □ |
| Grand Father | □ | □ | □ |
| Other:_____ | □ | □ | □ |

Where were you raised?_____ Ethnic/Cultural Background:_____

Describe your childhood family experience and home environment:

| | | |
|---|---|---|
| □ nurturing/loving home<br>□ normal/average home<br>□ neglectful home<br>□ financially stressed home | □ chaotic home<br>□ unpredictable home<br>□ frightening home<br>□ drug abuse home | □ alcohol abuse home<br>□ verbal/emotional abuse<br>□ physical/sexual abuse<br>□ witnessed abuse at home |

Parent's current marital status:

| | | |
|---|---|---|
| □ married to each other<br>□ separated from each other<br>□ divorced for _____ years | □ mother remarried___ times<br>□ mother in a relationship<br>□ mother widowed | □ father remarried____ times<br>□ father in a relationship<br>□ father widowed |

If your parents separated, how old were you?____ Who was your primary parent?_____

Parents:

Mother: Age:___ Year & age at death_____ Occupation:_____ Health:_____

Father: Age:___ Year & age at death_____ Occupation:_____ Health:_____

Step-Mother: Age:__ Year & age at death_____ Occupation:_____ Health:_____

Step-Father: Age:__ Year & age at death_____ Occupation:_____ Health:_____

Current or past quality of relationships with parents:

Mother: □ excellent □ satisfactory □ unsatisfactory □ poor Where she resides:_____

Father: □ excellent □ satisfactory □ unsatisfactory □ poor Where he resides:_____

Step-Mother:□ excellent □ satisfactory □ unsatisfactory □ poor Where she resides:_____

Step-Father: □ excellent □ satisfactory □ unsatisfactory □ poor Where he resides:_____



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Brothers and Sisters:

Number of biological siblings:___ Number of half-siblings?___ Number of step-siblings?___

Overall quality of relationships with your siblings: □ Great □ Satisfying □ Unsatisfying □ Poor

Explain:_____

| Biological Sibling Names | Age | Live where? | Quality of relationship? | Frequency seen |
|---|---|---|---|---|
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |

| Half-Sibling Names | Age | Live where? | Quality of relationship? | Frequency seen |
|---|---|---|---|---|
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |

| Step-Sibling Names | Age | Live where? | Quality of relationship? | Frequency seen |
|---|---|---|---|---|
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |
| _____ | ____ | _____ | _____ | _____ |

## Childhood and Early Adult History

Rate your childhood years up to 13 years old: □ great □ ok □ not very good □ lousy

Rate your teenage years between 13 to 18 years old: □ great □ ok □ not very good □ lousy



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Rate your young adult years from 20 to 30 years old: □ great □ ok □ not very good □ lousy

What were the best ages or years of your life?_____

From elementary to high school, rate your social life with school mates and friends:

□ great □ ok □ not very good □ lousy

Since your teenage years, rate your social life: □ great □ ok □ not very good □ lousy

Your grades in school were: □ above average □ average □ below average

Your overall experience in school was: □ great □ ok □ not very good □ lousy

Your greatest hero/heroine is_____ in_____. Why?____

_____

Your best memories and experiences in the past include:_____

_____

The one person in your life who you admire most is:_____

Why?_____

Special circumstances, losses or experiences during your childhood:_____

_____

## Educational History

Level of education: □ high school □ some college □ college degree □ masters □ doctorate

Currently enrolled at:_____

College(s) attended and year(s) graduated:_____

Education major/speciality:_____

Professional license/credential:_____



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## Medical and Psychological History

Describe your physical health: □ excellent □ good □ fair □ poor

Primary physician name:_____ Phone:_____ Last exam:__/__/___

Rate your relationship with your primary care physician: □ excellent □ good □ fair □ poor

Other physician name:_____ Phone:_____ Last exam:__/__/___

Other health professional:_____ Phone:_____ Last exam:__/__/___

Do you have a history of any of the following medical problems?

| | | |
|---|---|---|
| □ tuberculosis | □ heart disease | □ emotional problems |
| □ cancer | □ stroke | □ behavior problems |
| □ diabetes | □ high blood pressure | □ pain disorders |
| □ obesity | □ alcoholism | □ dementia |
| □ irritable bowel syndrome | □ drug abuse | □ thyroid problems |
| □ lung problems | □ prescription medicine misuse | □ schizophrenia |
| □ asthma | □ bi-polar disorder | □ other:_____ |

Main medications currently taken:

| Name | Dosage | # Times/Day | Reason for Medication | Prescribing Physician |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Type of psychiatric medicine ever taken:_____

Concerns or fears about your medical condition:_____

_____

Impact of your medical condition on your family or caregivers:_____

---

Future medical procedures/surgeries scheduled: Type:_____ Date:_____

Is there a history of any of the following issues in your family background?

| | | |
|---|---|---|
| □ tuberculosis | □ high blood pressure | □ obsessive thoughts |
| □ cancer | □ alcoholism | □ compulsive behaviors |
| □ diabetes | □ drug abuse | □ threatening/violent behavior |
| □ obesity | □ prescription medicine misuse | □ pain disorders |
| □ irritable bowel syndrome | □ bi-polar disorder | □ dementia |



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| | | |
|---|---|---|
| □ lung/breathing problems<br>□ asthma<br>□ heart disease<br>□ stroke | □ depression<br>□ anxiety<br>□ anger problems<br>□ sleep disorder | □ thyroid problems<br>□ legal problems<br>□ schizophrenia<br>□ other:_____ |

History of other psychological disorders or chronic or life-threatening physical diseases in your family? _____

_____

_____

Do you have any known allergies?_____

Describe any medical or psychiatric hospitalizations you've had:

Date:___/____ Age:_____ Reason:_____

Date:___/____ Age:_____ Reason:_____

Additional medical information: _____

_____

## Social History

Your current social support system *(check all that apply):*

□ strong support network □ few friends □ substance-abuse-based friends □ distant from family

Past social network:

□ strong support network □ few friends □ substance-abuse-based friends □ distant from family

Are you satisfied with your friends, colleagues and social network? □ No □ Yes

Names of 2 biggest supporters:_____

Your living situation:

With the people I live with now, I am: □ happy □ satisfied □ dissatisfied



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## Career and Employment History

Current Employment:

| | | |
|---|---|---|
| □ self-employed<br>□ employed and satisfied<br>□ employed but dissatisfied | □ unemployed<br>□ coworker conflicts<br>□ supervisor conflicts | □ disabled<br>□ unstable work history<br>□ retired |

Employer:

Name:_____ City:_____ Length of employment there:_____

Position/Title:_____ # Hours worked/week:____ Annual gross income: $_____

How important is your work or career? □ very □ somewhat □ little

What career goals do you have? What do you want to achieve?_____

_____

How satisfied are you with your career or employment now? □ very □ somewhat □ not

## Household Finances

Who currently lives full-time in the home(s) where your child lives?_____

_____

Current gross household income: $_____ (include spouse or live-in partner and others)

Are you satisfied with your income? □ yes □ somewhat □ no

Do you and your family struggle financially? □ yes □ somewhat □ no

Do you have plans to increase your income? □ yes □ no If yes, what are your plans?_____

_____

Do you have any debts that cause you stress? □ yes □ somewhat □ no If yes, what debt stresses you?_____



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## Personal Life Activities and Passions

What are you most interested in and passionate about?_____

_____

What brings you the most joy, pleasure and happiness in life?_____

_____

What sets off the most worry, fear or dread in your life?_____

_____

What are your top 3 most important goals, hopes and dreams to achieve in the future?

1. _____
2. _____
3. _____

What do you value the most in your life?_____

_____

Physical Exercise Activities:

How often do you actviely exercise? □ Regularly □ Occasionally □ Rarely □ Never

Rate your general physical condition now: □ Excellent □ Good □ Fair □ Poor

Describe the type, frequency and amount of time you exercise now:_____

_____

Recreational Activities:

List the hobbies, interests, sports or recreational activities that you regularly engage in:

_____

_____

Community Activities:

List the community, cultural, organizational or club activities that you regularly engage in:

_____

_____



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Religious/Spiritual Activities:

List the religious or spiritual activities that you regularly engage in. Add where and frequency:

_____

_____

## Legal History:

□ no legal problems □ divorce in process □ child custody dispute □ lawsuit(s) pending

□ driving under influence □ arrests(s) not substance related □ arrest(s) substance related

## Military History:

□ never in military □ service in military - no disciplinary incidents □ served in military - with disciplinary incident: If disciplined, explain:_____

Branch:_____ # years served:____ Discharge date:_____ Rank upon discharge:_____

## Substance Use History

Family alcohol/drug abuse history (*check family member(s) with alcohol/drug history*):

□ father □ mother □ step-father □ step-mother □ grandparent(s) □ sibling(s) □ children

□ current spouse/partner □ ex-spouse/partner □ uncle(s)/aunt(s) □ other:_____

Your current substance use:

| | | |
|---|---|---|
| □ no history of abuse<br>□ current active abuse<br>□ past abuse | □ early partial recovery<br>□ early full recovery | □ sustained partial recovery<br>□ sustained full recovery |



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Substance(s) used by you *(check all that apply):*

| Drug Used | First Use Age | Last Use Age | Currently Using | Frequency | Amount |
|---|---|---|---|---|---|
| □ alcohol | _____ | _____ | □ No □Yes | _____ | _____ |
| □ amphetamines/speed | _____ | _____ | □ No □Yes | _____ | _____ |
| □ barbiturates/downers | _____ | _____ | □ No □Yes | _____ | _____ |
| □ caffeine | _____ | _____ | □ No □Yes | _____ | _____ |
| □ cocaine | _____ | _____ | □ No □Yes | _____ | _____ |
| □ crack cocaine | _____ | _____ | □ No □Yes | _____ | _____ |
| □ hallucinogens (e.g. LSD) | _____ | _____ | □ No □Yes | _____ | _____ |
| □ inhalants (e.g. glue, gas) | _____ | _____ | □ No □Yes | _____ | _____ |
| □ marijuana or hashish | _____ | _____ | □ No □Yes | _____ | _____ |
| □ PCP | _____ | _____ | □ No □Yes | _____ | _____ |
| □ prescription medicine | _____ | _____ | □ No □Yes | _____ | _____ |
| □ smoke cigarettes | _____ | _____ | □ No □Yes | _____ | _____ |
| □ chew tobacco | _____ | _____ | □ No □Yes | _____ | _____ |
| □ other | _____ | _____ | □ No □Yes | _____ | _____ |

Consequences for substance use/abuse in past 5 years *(check all that apply):*

| | | |
|---|---|---|
| □ hangovers<br>□ withdrawal symptoms<br>□ sleep disturbance<br>□ binges<br>□ seizures<br>□ black outs/memory loss<br>□ assaultive behavior<br>□ domestic abuse problems<br>□ arrests | □ physical injury<br>□ emergency room visits<br>□ medical conditions<br>□ overdose<br>□ suicide attempt<br>□ relationship conflicts<br>□ relationship loss<br>□ job loss<br>□ legal problems | □ tolerance changes<br>□ loss of control of amount used<br>□ social rejection<br>□ family rejection<br>□ financial loss<br>□ home loss<br>□ property loss<br>□ auto accidents |

Other consequences:_____

Drug treatment and programs: □ inpatient treatment □ outpatient treatment □ AA □ NA



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## Inner Self-Talk and Self-Image

When you listen to your negative or critical inner voice, it tells you:_____

_____

When you listen to your positive or praising self-talk, it tells you:_____

_____

How often do you listen to your inner voices or self-talk: □ frequently □ on and off □ rarely

Turning off your negative self-talk is: □ easy □ difficult

Your self-image is: □ positive □ negative □ both positive & negative

Your self-confidence is: □ high □ moderate □ low

## Life Review & Future

When you think about your past, how many regrets do you have? □ some □ many □ none

Your main regrets include:_____

_____

You look forward to:_____

_____

## Attitude Toward Treatment with Dr. Miller

Your expectations about psychotherapy:_____

_____

What do you expect to gain from therapy?_____

_____

What do you want to receive from your therapy sessions?_____

_____

Your top 3 goals for therapy now:

1. _____
2. _____
3. _____



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What would your life look like and feel like if you reached these goals in therapy?_____

_____

What would your life look like and feel like if you did <u>not</u> reach these goals in therapy? _____

_____

Rate the severity of your problems now: □ mild □ moderate □ serious □ very serious

Explain:_____

Rate your current motivation to put in the effort needed to make changes in your life:

□ low □ mild □ moderate □ serious □ highly motivated

Estimate the number of psychotherapy sessions it might take to overcome your problems:

□ four □ ten □ twenty-five □ fifty

Rate your hope that you will overcome these problems:

□ little hope □ some hope □ very hopeful □ extremely hopeful

Rate your willingness and readiness to follow a treatment plan recommended by Dr. Miller:

□ reluctant □ willing to listen □ excited to hear □ may follow □ very willing to follow

Do you have a history of following advice from your health professionals?

□ sometimes □ usually □ always

Are you willing to trust, take risks and experiment with new ideas and behaviors in order to makes changes in your life? □ not much □ maybe □ Yes

What would you advise someone else to do if they suffered from the same problems that you have now?_____

_____

## <u>Completion of This Questionnaire</u>

Please describe what it was like to take this questionnaire:_____

_____

What question area(s) was/were the most difficult to answer honestly?_____

_____



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## Additional Information to Communicate

_____

_____

_____

_____

_____

_____

Thank you for completing this questionnaire and being forthright in your answers. Revealing personal and historical information is always a challenge. I know it was demanding and took concentration. You should be proud that you stuck with it.

This is an initial experience of what it will be like to work with me in psychotherapeutic treatment. You will need to trust, disclose, take risks, stay motivated, consider new perspectives, put in effort, and be willing to be seen as you are. That is the only way you will make changes, solve problems, manage your life better, and accept aspects of your situation that you cannot change.

**Revel Miller, Ph.D.**

_____

## Please Sign Below and Return to Dr. Miller.

I have answered these questions to the best of my ability.

_____ _____ ____/____/_____

Printed Name Signature Date



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