What Brings You Here?

Briefly explain what brings you here? _____

_____

_____

What do you hope to gain from your experience with counseling? _____

_____

_____

Client's Name: _____

Date of Birth: _____ Soc Security #: _____

Driver's License #: _____ State Issued: _____

Address:

Street _____

City _____ Zip _____

Phone Number: _____ Is it okay to leave a voicemail/text? Yes / No

E-mail Address: _____ Is it okay to send emails? Yes/No

Emergency Contact Name: _____

Phone Number: _____

Relationship to client: _____

Medical Insurance Provider: **PLEASE PROVIDE COPY OF CARD, FRONT AND BACK**

Primary Insured: _____

Date of Birth Primary Insured: _____

Employer: _____

Authorization Number (if applicable): _____

If using EAP, you must provide an authorization number and the EAP insurance agency. If the information you provide is not accurate, you may be responsible for full costs.

Educational Status: _____

Occupation: _____

Marital Status: Single / Married / Re-married / Co-habituating / Separated / Divorced / Widowed

Gender: _____ Ethnicity: _____

Hobbies: _____

Religious Orientation: _____

Social Activities: _____

Do you belong to or regularly attend any of the following;

Community clubs / Civic clubs / Church group / Other religious organizations / Other social networking group / Sport or Exercise group / Peer support group / Hobby or Special interest group / School Organization or club?

If so, please describe: _____

Do you have children? Yes / No

If yes, how many? _____

Please list the names and ages of your children and if they live in your home:

_____

_____

_____

_____

Primary Care Physician: _____

Medical Diagnosis (if applicable): _____

_____

Allergies: _____

Current Medications:

Name: _____ Name: _____

Dose: _____ Dose: _____

Purpose: _____ Purpose: _____

Name: _____ Name: _____

Dose: _____ Dose: _____

Purpose: _____ Purpose: _____

Have you ever sought mental health treatment before? Yes / No

If yes, please list the approximate dates and if it was helpful?

_____

_____

Have you ever attempted suicide (Yes / No) or self-harm behavior (Yes / No)?

If yes, please explain?

_____

_____

Have you ever experienced a head injury or been unconscious? (Yes / No)

If yes, please explain?

_____

Have you ever used alcohol excessively or to the point you felt it was problematic? Yes / No

If yes, please explain?

_____

_____

Have you ever used a substance (prescribed or not) to the point it was problematic? Yes / No

If yes, please explain?

_____

_____

Have you ever had a family member or a loved one use alcohol or substances to the point it was problematic? Yes / No

If yes, please explain?

_____

_____

Have you ever experienced a traumatic event or series of events? Yes / No

If yes, please explain?

_____

_____

Has anyone in your family ever been diagnosed with a mental illness or shown signs of mental health symptoms? Yes / No

If yes, please explain?

_____

_____

Have you ever been involved with the legal system (criminal or civil)? Yes / No

If yes, please explain?

_____

_____

Any other information you feel would be helpful for your therapist to review?

_____

_____

_____

Consent to Treatment

I authorize my counselor, Kathryn A. Robertson, LCSW (20682), to provide psychological counseling treatments which are advisable during the course of my care. The purpose of these procedures will be explained upon request and are subject to my agreement. It is expected that therapy is designed to be helpful and beneficial but at times may be difficult and uncomfortable. I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. To best serve my needs, Mrs. Robertson may confidentially consult or utilize the expertise of colleagues, while keeping your information anonymous.

I have read, or had read to me, the Consent for Treatment. I had an opportunity to ask any questions about the treatment process and what it means to consent to treatment. The questions, if applicable, were addressed to my satisfaction by Mrs. Robertson. I understand and consent to treatment. _____
Client Initials

Attestation/Receipt of General Policies/ Receipt of Privacy Policies and Your Rights under HIPPA

I received, reviewed, and had opportunity to ask questions regarding The King's Counseling Services' General Policies, Privacy Policies, and my rights under HIPPA. The questions, if applicable, were addressed to my satisfaction by my counselor. I feel comfortable and understand all the information provided. _____
Client Initials

Authorization for E-mail/Text Communication

I have been made aware of the limitations and possible benefits of communicating with my counselor for routine matters of communication like scheduling, billing, or non-emergency routine communication. I understand that there are risks to confidentiality and that my counselor cannot assure confidentiality if I choose to communicate with e-mail or text messaging. I have had an opportunity to ask questions regarding e-mail or text messaging communication. The questions, if applicable, were addressed to my satisfaction by my counselor.

I give permission to communicate via **e-mail** _____ and/or via **text messaging** _____
Client Initials Client Initials

_____ I **DO NOT** give permission to communicate via e-mail or text messaging.
Client Initials

Print your Name: _____

Signed: _____ Date: _____
(Client's signature)

Counselor: Kathryn A. Robertson, LCSW (20682)

Signed: _____ Date: _____
(Counselor's signature)