

**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?

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

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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?

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Have you ever experienced a traumatic event or series of events? Yes / No  
If yes, please explain?

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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?

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Have you ever been involved with the legal system (criminal or civil)? Yes / No  
If yes, please explain?

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

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**Consent to Treatment**

I authorize my counselor, Dr. Amy Tillery (PSY26063), 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, Dr. Tillery may confidentially consult or utilize the expertise of colleagues, while keeping my 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 Dr. Amy Tillery. 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: Amy L. Tillery, Ph.D, PSY26063

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Counselor's signature)