What brings your child here today?

Briefly describe your child: _____

_____

What do you hope for your child as a result of seeking therapy: _____

_____

Any concerns that your therapist should be aware of before treating your child: _____

_____

Client / Child Information

Client's Name: _____ Date of Birth: _____ Gender: _____

Ethnicity: _____ Client's Phone number: _____ Client's E-mail: _____
Is it okay to leave a voicemail/text? Yes / No Is it okay to send emails? Yes / No

Emergency Contact Name: _____ Phone Number: _____
Relationship to client: _____

Person Responsible for Payment: _____
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.

Parent/Legal Guardian's

Name: _____ Date of Birth: _____Occupation: _____ Gender: _____

Driver's License: _____ State: _____ Soc Security #: _____

Ethnicity: _____ Relationship to client: _____ % Custodial Time: _____

Visitation Schedule: _____

Phone: _____ E-mail: _____
Is it okay to leave a voicemail/text? Yes / No Is it okay to send emails? Yes / No

Address: Street _____

City _____ Zip _____

Parent/Legal Guardian's

Name: _____ Date of Birth: _____Occupation: _____ Gender: _____

Ethnicity: _____ Relationship to client: _____ % Custodial Time: _____

Visitation Schedule: _____

Phone: _____ E-mail: _____
Is it okay to leave a voicemail/text? Yes / No Is it okay to send emails? Yes / No

Address: Street _____

City _____ Zip _____

Client's Social Development

Siblings: _____

_____

Other's living in the home: _____

_____

Significant friendships/relationships (i.e. best friend, grandparents): _____

_____

_____

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: _____

Hobbies: _____

School: _____ Employer: _____

Medical / Other Information

Primary Care Physician: _____

Medical Diagnosis (if applicable): _____

Allergies: _____

Current Medications:

Name: _____ Name: _____

Dose: _____ Dose: _____

Purpose: _____ Purpose: _____

Name: _____ Name: _____

Dose: _____ Dose: _____

Purpose: _____ Purpose: _____

Has your child ever sought mental health treatment before? Yes / No

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

_____

Has your child ever attempted suicide (Yes / No) or self-harm behavior (Yes / No)?

If yes, please explain?

_____

_____

Has your child ever experienced a head injury or been unconscious? (Yes / No)

If yes, please explain?

_____

_____

Has your child ever used alcohol? Yes / No

If yes, please explain?

_____

_____

Has your child ever used a substance like prescription pain medicine, marijuana or other street drug? Yes / No

If yes, please explain?

_____

_____

Has anyone in your child's family used alcohol or substances to the point it was problematic? Yes / No

If yes, please explain?

_____

_____

Has your child ever experienced a traumatic event or series of events? Yes / No

If yes, please explain?

_____

_____

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

If yes, please explain?

_____

_____

Has your child ever been involved with the legal system (criminal or civil)? Yes / No

If yes, please explain?

_____

Consent to Treatment for Minor Child/Adolescent

I am legally able to provide medial authorization for _____. Therefore, I authorize Amy Tillery, Ph.D. (PSY26063) to provide psychological counseling treatments which are advisable during the course of clinical 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 he/she will benefit from psychotherapy but there is no guarantee that this will occur. To best serve his/her needs, Dr. Tillery may confidentially consult or utilize the expertise of colleagues, while keeping all information anonymous. Additionally, I understand that all information shared with Dr. Tillery will be held confidential, within the constraints listed in the policy and procedure section defining the limits to confidentiality.

I have read, or had read to me, the Consent to Treatment for Minor Child. 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 have read, or had read to me, the General Policies. I understand these policies and have had an opportunity to ask questions. The questions, if applicable, were addressed to my satisfaction by my counselor. I received, reviewed, and had opportunity to ask questions regarding The King's Counseling Services' Privacy Policies and my rights under HIPPA. The questions, if applicable, were addressed to my satisfaction by my counselor. I feel comfortable with the information about my rights and the Privacy Policies. _____
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

Parent or Legal Guardian's Name: _____

Signed: _____ Date: _____
(Parent or Legal Guardian's signature)

Counselor: Amy Tillery, Ph.D., PSY26063

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