Name: ______________________ Today's Date: ______________
Address: ______________________ Date of Birth: ______________
City: ______________________ SS#: ______________
State: ______________________ DL#: ______________
Phone: ______________________ Zip: ______________
Email: ______________________ Gender: ______________
Emergency Contact: ______________________ Orientation: ______________
Contact #: ______________________ Current Student: Yes No
Contact Relationship: ______________________ Highest Degree Complete: ______________
Current Employer: ______________________
Marital Status: ______________________ Occupation: ______________
Religious Orientation: ______________________
Social Activities: ______________________ Children: Yes No

Name of Child	Age	Living Arrangements

Primary Care Provider: ______________________ Provider Contact: ______________

Current Medical Diagnosis: ______________________ Known Allergies: ______________

Medication Name	Dosage	Purpose

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

Primary Insured Name: ____

Date of Birth Primary Insured: ____

Employer: ____

Client Primary Medical Insurance:

Member ID: ______________________

Group Number: ______________________

Client Secondary Insurance:

Member ID: ______________________

Group Number: ______________________

EAP Provider Name:

____

EAP Authorization Number: ______________

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.

	Yes	No
Have you sought mental health treatment before?		
Have you ever attempted suicide?		
Are you suicidal now?		
Have you ever engaged in self-harm behavior?		
Are you engaging in self-harm behavior now?		
Have you ever experienced a head injury or been unconscious?		
Have you ever used alcohol excessively?		
Have you ever abused a substance (prescribed or not)?		
Is there a family history of alcohol or substance abuse?		
Have you ever experienced a traumatic event (or series of events)?		
Do you have a history of involvement with the legal system?		
Is there a family history of mental illness (diagnosed, treated, or not)?		
Are you sleeping well?		
Has your appetite been usual for you lately?		

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 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 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. ________

Client Initials

Print your Name: ____

Signed: ____ Date: ___________________

(Client's signature)

Counselor: ___Kathryn A. Robertson, LCSW26063_____________

Signed: ____ Date: ___________________

(Counselor's signature)