

Adult Intake

The King's Counseling Services

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:

Client Secondary Insurance:

Member ID: _____

Member ID: _____

Group Number: _____

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, Dr. Amy Tackett (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. Tackett 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 Tackett. 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: _____

Sign this Form:

I declare this information to be true and complete. By clicking the box I'm indicating my electronic signature.

Date: _____

Counselor: Amy L. Tackett, Ph.D, PSY26063

Signed: 
(Counselor's signature)

Date: _____