Child: _____ Today's Date: _____

Phone: _____ Date of Birth: _____

Religious Orientation: _____ Gender: _____

Social Activities: _____ Orientation: _____

Ethnicity: _____

Parent 1: _____ Date of Birth: _____

Address: _____ SS#: _____

City: _____ DL#: _____

State: _____ Zip: _____

Phone: _____ Visitation Schedule:

Email: _____ _____

Parent 2: _____ Date of Birth: _____

Address: _____ SS#: _____

City: _____ DL#: _____

State: _____ Zip: _____

Phone: _____ Visitation Schedule:

Email: _____ _____

Emergency Contact: _____

Contact #: _____

Contact Relationship: _____

Name	Age	Relationship to Child	Percentage of Time with Child

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
Has your child sought mental health treatment before?		
Has your child ever attempted suicide?		
Is your child suicidal now?		
Has your child ever engaged in self-harm behavior?		
Is your child engaging in self-harm behavior now?		
Has your child ever experienced a head injury or been unconscious?		
Has your child ever used alcohol excessively?		
Has your child ever abused a substance (prescribed or not)?		
Is there a family history of alcohol or substance abuse?		
Has your child ever experienced a traumatic event (or series of events)?		
Does your child have a history of involvement with the legal system?		
Is there a family history of mental illness (diagnosed, treated, or not)?		
Is your child sleeping well?		
Has your child's appetite been usual lately?		

Consent to Treatment for Minor Child/Adolescent

I am legally able to provide medial authorization for _____. Therefore, I authorize Kathryn A. Robertson, LCSW (20682) 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, Mrs. Robertson may confidentially consult or utilize the expertise of colleagues, while keeping all information anonymous. Additionally, I understand that all information shared with Mrs. Robertson 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 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 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. _____
Client Initials

Parent or Legal Guardian's Name: _____

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

Counselor: Kathryn A. Robertson, LCSW (20682)

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