_____ _____

Client Name Chart #

Chris King Counseling
8810 South Yale Ave Suite B
Tulsa, OK 74137
918-212-8064; FAX:844-482-2279
info@chriskingcounseling.com

ASSESSMENT/ SCREENING PORTION:

Agency Name: Chris King Counseling Services, LLC Date: _____

Name: LAST:_____ FIRST:_____ MIDDLE INT.:_____
MAIDEN: If Applicable)_____

Source/Provider of Information: _____Phone #: _____

Address/City/St./Zip/Co; _____

Phone #: _____DOB: _____ Age: _____Gender: Male Female

Best way to contact you? _____Confidentiality Issues? _____

E-mail Address: _____

Can CKCS contact you with appt. reminders and updates? (yes no)

If yes- email or txt: _____

How did you hear about CKCS? _____

What would you like help with (reason for seeking services)?

_____
_____

What are your immediate/urgent needs(including medical)?:

_____
_____

Currently receiving or past services? _____yes _____no If yes, where?:_____

Residing with: (alone, family, friends…) _____ # in household: _____

Source of Income: __Employment __SSI __SSDI ___Food Stamp __TANF ____Other: ____

Insurance: __Private __Medicaid __Medicare __Private Pay __Other: __

Insurance Company_____

Insurance ID#_____ SSN: _____

Referred by (Primary): _____(Secondary): _____

Reason for referral: _____

Name of School attending: _____

_____ _____

Client Name Chart #

Race (check all that apply): _____Native American/Alaskan Indian _____Black/African American _____Asian___ Hawaiian/Pacific Islander ___White ___Other___ Ethnicity: Hispanic/Latino____

Emergency Contact Name: _____Relationship: _____

Emergency Contact Phone#: _____

Emergency Contact Address: _____

Guardian/Custodian: _____ Relationship: _____

Preferred Language: _____

Need any special help/equipment? ____ yes ____no If yes, describe_____

Assessment questions- Answer yes, no, n/a (not applicable).

Behavioral/ Substance use

_____

Within the last 90 days (3 months) have you had a significant period in which you have experienced:

1. Been preoccupied with drinking alcohol and/or using other drugs? **yes, no, n/a.**
2. Tried to stop drinking alcohol and/or using other drugs, but couldn't? **yes, no, n/a.**
3. Had problems caused by drinking/using drugs, and you kept using? **yes, no, n/a.**
4. Are you misusing and prescription medication or over the counter products? **yes, no, n/a.**
5. Problems with Gambling? **yes, no, n/a.**
6. Had problems with behavior that gets you into trouble at home/ school/ work? **yes, no, n/a.**
7. Experienced significant arguing and escalation with other people? **yes, no, n/a.**
8. Problems controlling your anger, or had volatile or violent behavior? **yes, no, n/a.**
9. Been charged with crime, been arrested, or been incarcerated? **yes, no, n/a.**

Comments on above questions:

_____

_____

Emotional/ Trauma

_____

During the past year (12 months) have you:

10. Serious Depression(felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern,difficulty going about your activities)? **yes, no, n/a.**
11. Are you feeling mad, sad, hopeless, nervous, or have you had a change in your sleeping, eating, or school performance? **yes, no, n/a.**
12. Serious Anxiety of tension (felt uptight, worried, unable to relax)? **yes, no, n/a.**
13. Being prescribed medication for psychological/emotional problem? **yes, no, n/a.**
14. Thoughts of harming yourself? **yes, no, n/a**
15. Thoughts of harming others? **Yes, no, n/a**
16. An attempted suicide? **yes, no, n/a.**
17. Hallucinations (heard/seen things others don't hear/see)? **yes, no, n/a.**
18. Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one? **yes, no, n/a.**
19. Experienced bullying or harassment that had a significant impact on your life? **yes, no, n/a.**
20. Had periods of time where you felt that you could not trust family or friends? **yes, no, n/a.**
21. Ever been afraid of your partner and/or family member? **yes, no, n/a.**
22. Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened? **yes, no, n/a.**

Comments on above questions:

_____

_____

_____ _____

Client Name Chart #

Social/ Recreational

During the past year (12 months) have you:

23. Had problems getting along with people that cause significant negative impact on your life? **yes, no, n/a.**
24. Felt isolated or unable to relate to people? **yes, no, n/a.**
25. Are you spending less time with friends, care less about your appearance, or feel alone? **yes, no, n/a.**
26. What social groups do you participate in and how often? _____
27. What recreational/ leisure activities do participate in and how often_____

Comments on above questions:

_____
_____

Vocational

_____

During the past year (12 months) have you:

28. Been unemployed for a significant period of time? **yes, no, n/a.**
29. Been unsatisfied with job in a way that has a negative impact on your life or your family? **yes, no, n/a.**
30. Experienced significant stress on the job? **yes, no, n/a.**
31. Been desiring a job or career change? **yes, no, n/a.**

Comments on above questions:

_____
_____

Educational

_____

Highest level of education completed: _____For students: Approximate days absent this semester: _____

During the past year (12 months) have you:

32. Had problems with school performance that had a negative impact on your life? **yes, no, n/a.**
33. Had other problems in the school setting that had a negative impact on your life? **yes, no, n/a.**
34. Participated in an individual education plan (IEP)? **yes, no, n/a.**
35. Been suspended or expelled? **yes, no, n/a.**

Comments on above questions:

_____
_____

Family

_____

During the past year (12 months) have you:

36. Had trouble in family relationships that have a negative impact on your life? **yes, no, n/a.**
    Is there family history of mental illness, or suicide? **yes, no, n/a.**

    Is there family history of addiction? **yes, no, n/a.**

    Is there adoption or foster care in your immediate family? **yes, no, n/a.**

Comments on above questions:

_____
_____

_____ _____

Client Name Chart #

Mental Health

_____

37. Have you received counseling or in-patient treatment before? **yes, no, n/a.**
If yes, describe including any diagnosis you received_____

CLIENT MEDICATION INFORMATION

To be used document all medication used for treatment of mental health issues and also any physical health issues by client:

Medication prescribed	**Dosage**	**Frequency**
_____		
_____		

STAFF USE ONLY- INTAKE ASSESSMENT:

PICIS INFO:

CAR SCORES **GAF**

___ Feeling/mood **_____**
___ Thinking/mental process
___ Substances
___ Medical/Physical
___ Family
___ Interpersonal
___ Socio/Legal
___ Self care/basic needs
___ Role Performance

Referrals:
Case Management:
Therapy- list type, frequency, rendering provider:__
Mental Health assessment- list type: _____
Social Services : _____

_____ _____

Client Name Chart #

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee session is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency.

A bill will be mailed directly to all clients who do not show up for or cancel an appointment. Thank you for your consideration regarding this important matter.

_____

(Client Signature) Date

_____

(Client's Parent/Guardian if under 18) Date

_____ _____

Client Name Chart #

Chris King Counseling Services, LLC.

CONSENT FOR TREATMENT AND PARTICIPANT ORIENTATION SUMMARY:

Clients will read and initial each section if it applies/if it does not apply mark N/A:

_____ I voluntarily agree to treatment and services from Chris King Counseling Services, LLC. I understand the reasons for this treatment and the services recommended.

MEDICATION MANAGEMENT

_____ I have prescribed medications and will provide consent for consultation with my physician. I further understand that Chris King Counseling Services, LLC does not provide medication monitoring as a service and that I should consult my physician with all needs or concerns related to medication.

DURATION

_____ This consent for treatment ends after my discharge from services, except that information necessary for payment for services provided may be provided after discharge from services.

CONFIDENTIALITY

_____ I understand my information is confidential. Information is not released to other agencies or persons without my written consent except under a legitimate subpoena; in a medical emergency; to meet the legal requirements of reports of abuse to children or elders; or if I present a danger to myself or others. I have been offered information on legal requirements and limitation of mental health confidentiality.

CLIENT RIGHTS

_____ I have received a copy of the synopsis of my client rights and have discussed with the agency. I am satisfied with how my rights were explained, and I understand them. I acknowledge that I can receive a full bill of client rights upon my request.

PAYMENT SOURCE RELEASE OF INFORMATION

_____ I understand those agencies or insurance or others paying for my treatment services may review my records or may require my provider to provide information from my client file. I agree and hereby authorize Chris King Counseling Services, LLC. to release any and all information requested by the agencies or parties paying for my services. I understand this specific consent for release of information ends only after third party payer claims are satisfied.

CERTIFICATION/ACCREDITING REVIEW

_____ I understand that my records may be reviewed by State agencies certifying receipt of services and/or compliance with requirements, or by accrediting agencies verifying the quality and completeness of services I receive. I understand and agree to the above conditions.

CONSENT FOR FOLLOW UP

I_____ agree _____ do not agree that I can be contacted for follow up and outcome of services.

PARTICIPANT RIGHTS AND RESPONSIBILITIES

_____ I have been offered a copy of the Client Orientation with my rights, responsibilities, and grievance/input procedures and the HIPPA privacy laws. I understand the information presented to me.

COURT REPORTS AND SUBPOENAS

_____ I understand that Chris King Counseling Services, LLC. does not provide forensic or child custody evaluations. I understand that fees may be associated with reports for court and responses to subpoenas.

SAFETY AND EMERGENCY PREPAREDNESS

_____ I understand the safe places for emergency shelter, where to go, and what alarms of signals are.

PHYSICAL CARE

_____ I understand my counselor and my physician need to consult at times.

Client (if over 14): _____Date: _____

Guardian: _____Date: _____

Staff: _____Date: _____

_____ _____
Client Name Chart #

Chris King Counseling Services, LLC
Authorization for Credit Card Use

All information will remain confidential

Name on Card: _____

Billing Address: _____ZIP CODE_____

Phone Number Where you can be reached: _____

Email Address to send receipt: _____

Credit Card Type: _____ Visa _____ Mastercard _____ Discover _____ AmEx _____ Flex Pay

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 or 4 digits located on the back of the credit card)

Insurance Co-Pay or Insurance Deductible Amount Patient is responsible for

Amount to Charge: $ _____ (USD)

I authorize **CHRIS KING COUNSELING SERVICES, LLC** to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder

Please Sign and Date Signature: _____

Print Name: _____

Return the completed and signed form to the following:
Chris King Counseling Services, LLC
Attention: Billing Office
8810 Yale Ave Suite B
Tulsa, Ok 74137