_____ _____

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#_____Group#_____ SSN: _____

Primary Insurance Holder Info (if different from above info):

Primary Holder Name: _____DOB: ____/_____/____

Insurance Billing Address:_____City/State/Zip:_____

How did you hear about us:

_____

_____ _____

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:

_____

_____

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:

_____
_____

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 Name Chart #

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**

_____ _____

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 14 & over) Date

_____

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

_____ _____

Client Name Chart #

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 (14 & over): _____Date: _____

Guardian: _____Date: _____

Staff: _____Date: _____

_____ _____

Client Name Chart #

Chris King Counseling Services, LLC
Authorization for Credit Card Use

All information will remain confidential

Prior to receiving services, our office requests that you provide a credit card to have on file. This information will be used to reserve appointments and ensure payment in the event that reimbursement is not made by an insurance company or otherwise. It may also be used for appointments canceled with less than 24 hours notice, because these are not covered by insurance, and it may be used for insurance copays and deductibles.

Name as it appears on the 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: ____/_____/____CCV: _____ (last 3 or 4 digits located on the back of the credit card)

I authorize **CHRIS KING COUNSELING SERVICES, LLC** to charge my credit card for fees related to rendered services. These fees include: copays/co-insurances, deductibles, services not covered by my insurance, and/or self-pay fees. **I understand that I will be able to provide payment through the method of my choice on any current balances**, however, any outstanding balances that are past due 30 days will be charged to the credit card on file, unless other arrangements have been made.

This authorization is valid until I provide Chris King Counseling Services, LLC, with a written notice of cancelation.

Cardholder

Signature: _____ Date: _____

Print Name: _____

Witness: _____ Date: _____

Client Name _____ Chart # _____

Trauma/Risk Assessment

Check all risk and protective factors that apply. To be completed following the patient interview, review of record (s) and/or consultation with family members and/or other professionals.

General Consumer Information

In the past few weeks, have you been feeling bad about yourself/or that you are a failure /or have let yourself or your family down?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you had trouble falling asleep, staying asleep or sleeping to much?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you had thoughts about harming or killing yourself?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

Are you having thoughts or plans of killing yourself right now?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you felt the urge to hurt others?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

In the past few weeks, have you been having thoughts about hurting or killing others?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

Are you having thoughts of killing or harming others currently?
☐ Never ☐ Sometimes ☐Often ☐ I don't know

Additional Information

Please list any concerns or comments below.

Personal Information

Please provide the following information.

First Name _____ Last Name _____ Gender _____ Age _____

Address _____ City _____ State _____ ZIP Code _____

Email _____ Phone _____

Provide the following resources to all Consumers
24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Espanol : 1-888-628-9454
24*/7 Crisis Text Line : Text "HOME" to 741-741