kbl scottsdale counseling & consulting

LAST NAME OF CLIENT | FIRST NAME | MI

ADDRESS | CITY | STATE | ZIP CODE

PHONE (H) | (W) | (C)

DATE OF BIRTH | EMAIL

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER

RESPONSIBLE PARTY ADDRESS AND PHONE

RESPONSIBLE PARTY | ADDRESS | PHONE:

CLIENT'S EMPLOYER | ADDRESS

OCCUPATION:

TYPE OF BUSINESS:

HOW WERE YOU REFERRED:

IN CASE OF EMERGENCY WHO MAY WE CONTACT

NAME:

RELATIONSHIP: | PHONE:

CLIENT INFO

WHAT CONCERNS BRING YOU TO COUNSELING?

HAVE YOU HAD COUNSELING IN THE PAST? ☐YES ☐NO IF YES, PLEASE EXPLAIN

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? ☐YES ☐NO IF YES, PLEASE EXPLAIN

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

DOSAGE	REASON FOR TAKING	PRESCRIBING PHYSICIAN

HAVE YOU EVER HAD THOUGHTS OF SELF HARM OR HARMING ANOTHER? ☐YES ☐NO IF YES, PLEASE EXPLAIN

TREATMENT PLAN (TO BE COMPLETED WITH THERAPIST)

HOW WILL YOU KNOW WHEN YOUR THERAPY GOALS HAVE IMPROVED OR RESOLVED?

PAYMENT FOR SERVICES IS DUE AT THE TIME OF YOUR SESSION.
I UNDERSTAND I WILL BE CHARGED IN FULL IF I DO NOT PROVIDE 24 HOURS CANCELLATION NOTICE.
I/WE CONSENT TO CONSULTATION AND OR TREATMENT:

X SIGNATURE OF CLIENT **TODAY'S DATE**

PRIVACY PRACTICES ACKNOWLEDGEMENT: I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES (PSYCHOTHERAPISTS-PATIENT SERVICES AGREEMENT) AND HAVE BEEN PROVIDED AN OPPORTUNITY TO READ AND REVIEW IT.

X SIGNATURE OF CLIENT **TODAY'S DATE**

X SIGNATURE OF SPOUSE

X PARENT OR RESPONSIBLE PARTY **TODAY'S DATE**