Priscilla J. Colvin King, LLC
Adult Information Form

Please Print ______________________________________ Date________

Please complete the following. This information will be kept confidential.

Name____
Address ____
City ____________________________________**State** ____________**Zip Code** __________
Sex: Male ______ **Female** ______**Age** __________**Date of Birth** _____________________
Home Phone ___________ **Work Phone** _____________**Cell Phone** _________________
E-mail address ____
Are there any special instructions regarding contact information?___________________

____
***Person responsible for payment other than yourself:** __________________________
Address: ____
City _______________________________**State** ___________**Zip Code** ___________
Home Phone ______________________**Cell Phone** ____
*** Emergency Contact (if different from above)** ______________________ ________________________
Cell Phone _________________**Home Phone** ________________**Work Phone**________________

***completion of this information gives me permission to contact these people. If you choose to leave the emergency section blank, should an emergency arise, I will contact 911.**

Your occupation (please specify' if you are a student) ___________________________ _________
Your employer (or name of school if student) ________________________ ___________________ __
Religious affiliation ______________________**Place of worship**_____________________ _____ _
How did you hear about me? ____
Relationship Status: Single _____**Married**_____ **(Number of years)**________
Divorced ______**Separated** ______**Widowed** _____**Dating** ______
Briefly describe your level of satisfaction with this status:
____

Family Members living with you

Name	Relationship	Age	Education level	Occupation
________________	________________	_____	_______________________	_____________
________________	________________	_____	_______________________	_____________
________________	________________	_____	_______________________	_____________
________________	________________	_____	_______________________	_____________
________________	________________	_____	_______________________	_____________
________________	________________	_____	_______________________	_____________

Have you seen a counselor before? _____Yes ______No
If yes, please indicate who, when, where, and why

____

____

Please list any significant medical diagnoses/conditions that you have:___________________

____

____

____

Please list all medications, both prescription and over the counter that you take. Please include the **dosage. and the reason for taking**.

____

____

____

Please complete the following:

1. The most important thing to me is _____________________
2. I worry about ________________________________
3. I have sometimes felt guilty about_________________________
4. I have been criticized for _______________________________
5. I get angry when _____________________________
6. I get nervous when _______________________________
7. My biggest problem in life is ____________________________
8. I often felt that my father was ___________________________
9. I often felt that my mother was ________________________
10. My biggest mistakes are _____________________________

Problem Areas: Put a check mark next to each item that identifies an area of concern to you. Place two checks by those items, which most concern you.

___________	Anger	___________	Trouble Making Decisions
___________	Unhappy most of the time	___________	Depression
__________	Use of alcohol	__________	Work
___________	Use of alcohol by a family member	___________	Worry
__________	Use of drugs	__________	Eating Concerns
___________	Use of drugs by a family member	___________	Problems with Children
___________	Use of tobacco	___________	Problems with Parents
__________	Education	__________	Fearfulness
___________	Financial difficulties	___________	Marital Problems
___________	Physical problems	___________	Thoughts of Suicide
____________	Problems with social relationships	____________	Sleep Problems
___________	Religious/Spiritual concerns	___________	Sexual Concerns
___________	Thoughts of hurting others	___________	Other (give description)

What is the primary reason you scheduled this appointment?

____

____

____

I, ___________________________________, give my permission to Priscilla J. King, M.A., LPC, to release information, as requested by the insurance company and its representatives, to my insurance company and its representatives. I realize that my insurance company may contact Polly King or The Callaway Group (my billing service) with a need for additional information in order to process my claim. My signature below indicates that Polly or Martha with Callaway has my permission to release information to my insurance company and its representatives by phone, FAX, or mail about issues/questions related to my claim. I agree to no expiration date regarding this permission.

Signature: ________________________________Date: __________

Revised 11/09

Priscilla J. Colvin King, LLC
Couple Information Form

Please Print

Name ____Age ___________________Date______________

Address____

City ___________________________________State ____________________Zip Code _______________

Home Phone _____________________Work ___________________Cell __________________________

E-Mail address ____

Person responsible for payment if other than you ____

Address ____

City ____State ____________Zip Code _________________

Home Phone _________________________________Work _________________________Cell __________

Your Occupation _________________________Your Employer ___________________________________

Religious affiliation ____________________Place of Worship ___________________________________

How did you hear about me? ____

How long have you been married? ____

Have you been married before? Yes _______No ______How many times? _________________________

Have you ever seen a counselor before? _____Yes _____No If so, when ___

Family members living with you:

Name	Relationship	Age	Education Level	Occupation

List any significant medical diagnoses/conditions that you have ______________________________

____ ___

List any medications you are currently taking **include dosage and the reason taking:** _________

____

____

How often do you have mild arguments?____

How often do you have severe arguments? ____

Which of the following situations or behaviors may contribute to conflicts? Label each behavior with the responsible party.

M=My behavior **S=Spouse's behavior** **B=Both**

_______	Use of alcohol	_______	Childishness
_______	Control	_______	Defensiveness
_______	Degrading	_______	Drugs
_______	Flirting with others	_______	Gambling
_______	Irresponsibility	_______	Lies
_______	Past relationship	_______	Outside interests/activities
_______	Perfection	_______	Possessive
_______	Spends too much	_______	Unstable
_______	Violent	_______	Works too much
_______	Pornography	_______	Use of drugs
________	Other (Specify)		

____

____

____

____

Please respond to the following in regards to your marriage: Write Yes or No in the spaces below:

______**Does** it seem that you and your spouse have very little in common?

______Do you feel distant from your spouse?

_____ Do you and your spouse have trouble communicating?

_____ Are you and your spouse defensive with each other?

_____ Do arguments often get out of control?

______Do you trust your spouse?

______Does your spouse usually express his/her anger inappropriately? __Are you physically afraid of your spouse?

_____ Do you often feel controlled by your spouse?

__ Do you often feel that arguments never get resolved?

__ Do you often feel unappreciated?

______ Do you often feel judged or made fun of by your spouse?

_____ Do you feel that your spouse might leave at any time?

_____ Do you feel that you are not the first priority for your spouse?

______Do the children take priority over you in your relationship?

______Does your spouse fail to do his/her fair share around the house?

______Do you have strong disagreements about finances?

______Do you have strong disagreements about parenting?

______Do you have strong disagreements about sex?

______Do you feel unattracted sexually to your spouse?

______Do you have strong disagreements about friends?

______Do you have arguments over religious beliefs?

______Do you have strong disagreements about extended family members?

______ Does your spouse's drinking or drug use affect the relationship?

______Do you feel hopeless that anything can change for the better?

I, hereby give my permission for Priscilla (Polly) J. King to share the information that I provide on this form to ________________________(spouse) when it is deemed appropriate. This sharing of information may take place only during a joint counseling session.

Client signature ____________________________________Date ________

Priscilla J. King LLC
4485 Tench Road
Suite 840
Suwanee, Ga 30024

Insurance Assignment Sheet

Client Name ___________________________________
Date of Birth __________________________________
Policyholder/Employee *(if* different from client)____
Date of Birth____
Employer____
Insurance Company ____
Insurance Company Phone number ____
Insurance Identification number _______________________Group number _______________________

I hereby instruct and direct ____________________Insurance Company to pay by check or direct transfer payment for the behavioral health benefits allowable and payable toward charges for the professional services rendered to:

Priscilla J. Colvin King LLC
4485 Tench Road
Suite 840
Suwanee, GA 30024
EIN # 26-1526048

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A photocopy of this assignment shall be considered as effective and valid as the original.

Signature of Policyholder ___________________________Date _______
or Claimant if other than policyholder

ADOLESCENT SENTENCE COMPLETION

NAME ________________________AGE________________ GRADE______________

1. The most important thing to me is____
2. I worry about ____
3. What hurts me most is ____
4. 1 get nervous about ____
5. I have sometimes felt guilty about____
6. 1 have been criticized for ____
7. What makes me angry is ____
8. I can't ____
9. My biggest mistakes ____
10. Most boys ____
11. Most girls ____
12. 1 often feel that my mother ____
13. 1 often feel that my father ____
14. The future ____
15. My temper is ____
16. My home is ____
17. With other kids my age I ____
18. God to me is ____
19. When I was younger ____
20. I love to ____ .___

Priscilla J. Colvin King, LLC
Adolescent Information

Please provide the following information regarding your child/adolescent.

Please Print **Date ____________________**

Name ____

Address ____

City ______________________________State _____________Zip Code ____________

Sex: Male ______Female _____Date of Birth ______Age _________________________

Parent/Guardian Name ____

Address (if different from child) ____

City ________________________________State ____________Zip Code ____________

Father's Home Phone _______________Work ______________ Cell _______________

Mother's Home Phone _____________Work ________________Cell _______________

Person responsible for payment (if different) _____________________________________

Address____

City ______________________________State _________________Zip Code_________

Home Phone ____________________ Work _____________Cell __________________

How did you hear about me? ____

Religious affiliation ___________________Place of Worship _______________________

The information below will be helpful in understanding your child/adolescent. Please give me as much information as you think will be helpful. You may use the back of the sheets to give additional information.

Reasons for scheduling this appointment

____

____

____

____

____

____

Medical History (List major illnesses, operations and injuries. Indicate age when occurred and describe how severe. List any previous psychological, psychiatric, or neurological evaluations. List any known allergies, vision, hearing, or speech problems.

____
____
____
____

When did your adolescent last have a physical examination? ___________

List any prescription medications currently taking, dosage and reason for taking.

____
____
____

Please list all people now living in the household

Name	Age	Relationship to Adolescent	Highest Grade of Ed	Occupation
____________	______	______________________	__________________	_____________
____________	______	______________________	__________________	_____________
____________	______	______________________	__________________	_____________
____________	______	______________________	__________________	_____________

Family history

(Include adoptions, re-marriages, previous marriages, and deaths in immediate family). Is the adolescent aware of this history?

____
____
____
____
____
____

Were there any early patterns or experiences that you believe caused the current problems?

____
____
____

Describe Your Adolescent's Current Functioning and Habits:

Appetite and eating habits ____

Sleep patterns: ____

Level of activity ____

Any problems sitting still or paying attention ____________________________________

Nervous habits such as hair pulling nail biting etc.) ______________________________

____

Other habits or behavior that concern you (use of alcohol/drugs, smoking, cursing, shoplifting, obsessive worry, obsessive thoughts, etc.)

____

____

____

Getting along with others

____

____

Pattern of interaction with opposite sex and any concerns about dating or sexual activity or identity

____

____

What your adolescent likes to do for fun, special interests, hobbies, etc.

____

____

Your method of discipline and how your adolescent reacts to discipline

____

____

____

Education History

Name of School ________________________________Grade ________________________________

School counselor ____

The school will not be contacted without a signed release of information.

List previous schools attended and dates or grades

____

____

____

Has your adolescent ever repeated a grade? Yes _No _If so, what grade? _________________________

If, so what was the reason? ____

What are his/her grades like now? ____

Describe any learning difficulties ____

____

Have there been any discipline or other behavior difficulties at school? Yes ____No

If so, please describe ____

____

Religious Background

Describe religious experiences, training, worship attendance, concept of God etc.

____

____

Problem Areas: Place a check next to each item, which identities an area of concern. Please place two checks by those items of most concern.

______ Anger

______ Depression

______ Eating difficulties

______Education

______Fearfulness

______Unhappy most of the time

______Religious/Spiritual concerns

______Problems with siblings

______Problems with parents

______Problems with relationships with opposite sex

______Problems with relationships with same sex

______Other (describe below)

______Worry

______Sleep problems

______Thoughts of hurting others

______Thoughts of suicide

______Trouble making decisions

______Use of alcohol

_____Sexual Concerns

_____Use of drugs

_____Use of tobacco

Information shared with me by your adolescent is confidential. Exceptions include a danger to self or others, or a report of abuse.

If your insurance company contacts us to obtain information necessary to process your claims (such as diagnosis, dates of service, etc.) do we have your permission to provide such information by phone, FAX, or by mail? Yes _________No ____

____ ___________________________

Parent/Guardian Signature Date

____ ___________________________

Witness (Office Staff Member) Date

Thank you for your time in completing this form.

Revised 1/09