

**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

CHILD/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. I get nervous about _____
5. I have sometimes felt guilty about _____
6. I 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. I often feel that my mother _____
13. I 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
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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.

- | | |
|--|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Eating difficulties | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Education | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Trouble making decisions |
| <input type="checkbox"/> Unhappy most of the time | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Religious/Spiritual concerns | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Problems with siblings | <input type="checkbox"/> Use of drugs |
| <input type="checkbox"/> Problems with parents | <input type="checkbox"/> Use of tobacco |
| <input type="checkbox"/> Problems with relationships with opposite sex | |
| <input type="checkbox"/> Problems with relationships with same sex | |
| <input type="checkbox"/> Other (describe below) | |

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