AK Counseling AKCounselingMadison@gmail.com | 608.567.4648 | AKCounselingMadison.com

Name _____ Date _____

Age _____ Gender _____ Email _____

Home phone _____ [ ]preferred **Cell phone** _____ [ ] preferred

How you **heard about** AK Counseling _____

Your appt. was scheduled via [ ] Email [ ] Text [ ] Phone [ ] Other _____

I prefer to be contacted by [ ] Email [ ] Text [ ] Phone [ ] Other _____

Reason(s) for seeking therapy _____

_____

Reason(s) AK Counseling seems like a **good fit** for me _____

_____

Education level _____ Occupation _____

Place of **employment** _____ Duration of this employment _____

On a scale of 1-10 ('10' = very much and '1' = not at all) how happy are you with your job/career/employer? _____

Explain your rating _____

Physical health symptoms & diagnoses _____

Are you receiving treatment or medication for these symptoms/diagnoses? [ ] yes [ ] no

Do you get annual physical exams? [ ] yes [ ] no When was your last physical? _____

Do you **exercise** 20 minutes 3 times/week? [ ] yes [ ] more [ ] no

How often do you drink alcohol? _____ Consume marijuana? _____ Cocaine? _____

Methamphetamines? _____ Heroin? _____ Other recreational drugs? _____

How much do you consume, each time, on average? _____

Would you *like to* or feel you *need to* change your consumption of any substance mentioned above? [ ] yes [ ] no

Mental health symptoms & diagnoses (past & present) _____

_____ Receiving treatment or medication? [ ] yes [ ] no

List all **current prescription & non-prescription** medications, supplements, etc. (and doses if possible)

_____

_____

Challenges of significant magnitude for you

*1) Mark an "**X**" in the boxes that apply to your **past** 2) **Circle** what **currently** applies to you*

Anger/ Aggressive behavior	Depression	Stress	Anxiety/panic
Fears/Phobias	Obsessive thinking/Worry	Procrastination	Trusting others or yourself
Suicidal thoughts/Attempts	Self-mutilation	Moodiness (Year-round? Seasonal?)	Negativity
Perfectionism	Memory	Confidence/Self-Esteem/Inferiority	Energy/Ambition
Life purpose/Fulfillment	Irritability	Grief	Constructive communication
Attention/Concentration	Making decisions	Education	Career/Job
Sleep/Nightmares	Trauma/PTSD/Flashbacks	Eating problems/body image/weight	Money
Compulsive behaviors	Chronic illness	Abuser/Abused (physical, mental, emotional, $$, etc.)	Substance use (alcohol, tobacco, illicit drugs, prescription drugs, etc.)
Jealousy	Communication	Maintaining a "fake" image to appease others	Friendships / Healthy recreation
Family	Children	Other:	

Anxiety surrounding intimacy	Sexual desire	Unmet needs in a partnership	Sexual frequency
Infrequent orgasm	No orgasm	Painful intercourse	Rape/Sexual abuse
Sexual practices (BDSM, kink, etc.)	Never had intercourse	Sexual orientation	Premature ejaculation
LGBTQ related issues	Communication in intimate relationships/ Conflict	STDs	Lack of partner
Separation	Divorce	Multiple partners	Gender transition (past, current, future)
Erection difficulty	Non-traditional relationship(s)	Other:	

Treatment History

Prior therapy? [ ] yes [ ] no How long? _____ Dates/Years _____

What have been your **goals** in past therapy? _____

_____

What did you **like** about it? How was it **helpful**? _____

_____

_____

What ***didn't* you like** about it? How was it **unhelpful**? _____

_____

_____

Partner Status (circle below) How long have you had this status? _____

Single Dating Long-term partner Domestic partnership Widowed Married Divorced Poly/Open/Swing
Other _____

Partner name(s) & age (s) _____

If you have **children**, name(s) & age(s) _____

_____

Do you have a **family history** of (circle those that apply) [ ] Alcoholism [ ] Drug Abuse [ ] Other addictions

[ ] Psychosis [ ] Domestic violence [ ] Legal trouble (incarceration, felonies, bankruptcy, etc.) [ ] Neglect

[ ] Suicide attempts/success [ ] Depression [ ] Anxiety [ ] Trauma [ ] Bipolar or Schizophrenia

[ ] Physical abuse [ ] Verbal abuse [ ] Learning disability [ ] Obsessive Compulsive disorder

[ ] Other _____

Is your family a source of **support** for you? [ ] yes [ ] no Who are your strongest source(s) of support?

_____

Emergency contact (name, relation to you, phone number) _____

Do you have a history of criminal activity/charges or other **legal** concerns? _____

I, _____ certify that the information I provided is correct to the best of my knowledge and I have not purposefully misrepresented any information. I will not hold my therapist at AK Counseling, Inc. responsible for errors or omissions that I may have made in completing this form. Staff at AK Counseling, Inc. has my permission to contact the person I have listed as my emergency contact, can identify themselves as calling from AK Counseling, Inc. or as my "therapist" but without my additional consent cannot discuss details of my treatment with this individual.

SIGNATURE: _____ DATE: _____

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Guidelines

Please initial next to each bullet point to confirm your compliance.

_____ Please TEXT me as soon as you know you cannot attend your scheduled appointment. Notification via email or phone is also acceptable but *I will receive a text quickest*. You are subject to being charged the full or partial rate if notice is less than 24 hours or if you are a no-show.

_____ I am legally obligated to report to authorities if you express intent to harm or impose death upon yourself or others; everything else is kept confidential (refer to the Informed Consent page for exemptions).

_____ If I see you in a public setting, out of respect for you I will not initiate communication in order to preserve confidentiality. If you want to initiate communication you can, and I won't be offended if you don't.

_____ Initial appointments are typically between 60 and 90 minutes. Please indicate at the start of a session if you have a time restriction.

_____ Payment is due at the end of each session. I accept ALL major credit cards, cash, and checks.

_____ Visit AKCounselingMadison.com/Rates for current hourly rates. After 60 minutes, appointments are charged by the quarter hour (75, 90, 105, or 120 minutes)

I have read and understand all of the above statements. (Signature) _____

PLEASE, PLEASE MAXIMIZE YOUR THERAPEUTIC EXPERIENCE

_____ You are here because there is something(s) in your life you would like to be different. These topics may be difficult to discuss, and you can be sure this is a safe place to do it. I will not pass judgment no matter what you tell me.

_____ Make yourself comfortable. If you want, try settling your nerves by lying on the couch, diverting eye contact, writing down what you want to discuss so I can initiate discussion about it. Let me know if I can help you be more comfortable.

_____ I am here to help you make the changes you want/need at your own pace.

_____ I encourage feedback (verbal or written) about your experience.

_____ Please remember that communication via technology (e.g. email, text, etc.) is not 100% secure. Therefore you risk a breach in confidentiality when using this medium. You agree not to hold AKCI accountable for such a breach.

I have read and understand all of the above statements. (Signature) _____

I look forward to working with you! -Alison

"A smooth sea never made a skillful sailor" – English proverb

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Patient Rights & Informed Consent

The following are your rights as a person seeking outpatient mental health care under Wisconsin Statute Sec. 51.61.

TREATMENT RIGHTS

o Receive prompt and adequate treatment

o As a voluntary patient you may refuse any services, treatment, and/or pharmacological and supplement suggestions offered. It is your choice as to whether or not you take prescribed medication or supplements.

o You can refuse to participate in experimental research.

PRIVACY RIGHTS

o Refuse to be filmed or taped without your consent

o Your treatment records and conversation about your treatment are kept confidential (Wisconsin Statute Sec. 51.30)

o You have access to your treatment records

o Request restrictions on the use of your protected mental health information; however, there are circumstances by which we are not required to agree with the request (e.g. court subpoena; you report intent to inflict harm or death upon yourself or someone else).

FILE A GRIEVANCE

If you feel that your rights have been violated you have the right to report your grievance to AK Counseling.

INFORMED CONSENT

All services at AK Counseling, Inc. are voluntary. You have the right to refuse any aspect of treatment. You have the right to be informed by your therapist about:

o The benefits, alternatives, side effects, and administration of treatment

o The consequences of not receiving the proposed treatment

o This consent will be effective until treatment is terminated or you exercise your right to withdraw

I have read and understand the above information.

_____

Printed name

_____ _____

Signature Date