Appointment was scheduled via [ ] Email [ ] Text [ ] Phone

AK Counseling

New Client Intake

[Complete all 6 pages and bring to your first session]

Name _____ **Date** _____

Address _____

Age _____ Gender _____ **Email** _____

Cell phone _____ **Preferred method of contact [ ] Email [ ] Text [ ] Phone**

Ok for AKCI to text message? [ ] Yes [ ] No

* * * *

Education level _____ Occupation _____

Employer _____ Duration _____

How happy are you with your job/career? (1=not at all 10=very much) _____Explain _____

_____

Do you have daily structure? _____

* * * *

Physical health [ ] Poor [ ] Fair [ ] Good [ ] Excellent | Symptoms/Diagnoses _____

Exercise 20min. 3x/wk? [ ] More [ ] Yes [ ] No Quality of sleep (1=poor 10=great) _____ Average hours/night _____

Consume [ ] Marijuana [ ] Alcohol [ ] Caffeine [ ] Nicotine [ ] Other_____

How often? How much? _____

* * * *

Mental health [ ] Poor [ ] Fair [ ] Good [ ] Excellent Symptoms/Diagnoses_____

_____

Current prescription medications _____

Current supplements _____

Level of stress (1=none 10=too high) _____ Stress relievers _____

How well do you manage stress? _____

Mood stability? [ ] Poor [ ] Moderate [ ] Good

Prior therapy? [ ] Yes [ ] No How long? _____ Dates/years _____

Past therapy goals_____

Liked/How was it helpful?_____

Disliked/How was it unhelpful? _____

Do you see getting help as a strength or weakness? _____

Reason(s) you are seeking therapy now _____

* * * *

Do you feel safe at home? [ ] Yes [ ] No Who lives with you? _____

Do you feel lonely? (1=always 10=never)_____ How frequently do you have face-to-face interaction with friends?

_____

What makes you feel cared for? _____

Personal strengths _____

Personal areas for improvement _____

Do you feel your use of technology could be less? Explain _____

* * * *

Partner status [ ] Single [ ] Dating [ ] Long-term partner [ ] Domestic partnership [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Polyamorous [ ] Open [ ] Swing [ ] Other _____

How long have you had this status? _____ Desired status? _____

Partner name(s) & age(s) _____

Substance use concerns about your partner(s)? _____

Children, name(s) & age(s) _____

Family history [ ] Alcoholism [ ] Anxiety [ ] Biploar or Schizophrenia [ ] Drug abuse [ ] Domestic violence/abuse [ ] Depression [ ] Learning disability [ ] Legal (incarceration, felony, bankruptcy, sued, etc.) [ ] Neglect [ ] Trauma [ ] Psychosis [ ] OCD [ ] Other _____

Is your family a source of support for you? [ ] Yes [ ] No

Who are your strongest sources of support? _____

Emergency contact Name, Relation to you, Phone number _____

Past or present criminal activity/charges? _____

YOUR MOST *SIGNIFICANT* LIFE CHALLENGES

Mark an **"X"** if it applies to your **PAST** & an **"O"** if it **CURRENTLY** applies

Anger	Anxiety	Aggressive behavior	Abuse (physical, mental, $$, etc.)	Ambition	Body image/weight	Career/job
Children	Concentration	Communication	Depression	Education	Over eating	Under eating
Energy	Fear	Friendships	Addiction (porn, gambling, etc.)	Grief	Jealousy	Memory
PTSD	Perfectionism	Pessimism	Life purpose/fulfillment	Making decisions	Money	Panic Attacks
Phobias	Sleep	Procrastination	Moody/Irritable	Shame	Recreation	Stress
Suicidal thoughts	Suicide attempts	Self-mutilation	Maintaining a 'fake' image to appease others	Substance use	Obsessive thoughts	Compulsive behavior
Family	Trauma	Trusting others	Trusting self	Worry	Other	

Anxiety surrounding intimacy	Sexual desire HIGH LOW	Unmet needs in partnership	Sexual frequency TOO MUCH TOO LITTLE
Infrequent orgasm	Delayed ejaculation	No orgasm	Erection difficulty
Painful intercourse	Rape/Sexual abuse	Sexual practices (BDSM, Kink, etc.)	Have not had intercourse
Sexual orientation	LGBTQ	Communication/Conflict in intimate relationships	Sexually transmitted disease(s)
Lack of partner	Multiple partners	Gender transition (past, current, future)	Non-traditional relationship(s)
Other			

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 full or partial rate charge if notice is less than 48 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 exceptions).

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

_____ Visit AKCounselingMadison.com/Rates for current hourly rates. After 60 minutes, appointments are charged by the quarter hour (75, 90, 105, or 120 minutes). Payment is due at the end of each session via major credit card, cash, check, and HSA/FSA card.

_____ 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.

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

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 - lie on the couch, divert eye contact, or write down what you want to discuss so I can initiate dialogue. Let me know if there are other ways to address your comfortability.

_____ I encourage feedback (verbal or written) about your experiences in session so adjustments can be made to maximize the therapeutic effect.

_____ 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 and you agree not to hold AKCI/Alison Kilkelly liable.

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

Patient Rights and 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, Inc.

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

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 I may have made in completing the *New Client Intake* paperwork. My therapist at AK Counseling, Inc. has my permission to talk to my emergency contact and 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.

If I, _____, receive counseling/coaching services with Alison Kilkelly, LCSW via Skype, I acknowledge that this medium is not HIPAA compliant and therefore waive all rights to privacy and waive all liability of AK Counseling, Inc.. I understand I can request to meet for therapy in a HIPAA compliant teletherapy modality before engaging in virtual therapy with Alison Kilkelly, LCSW.

_____ _____

Signature Date