AK Counseling

AKCounselingMadison@gmail.com | 608.567.4648 | 313 Price Place Suite 205

New Client Intake [Email in advance or bring to your first session]

Scheduled via [ ] Email [ ] Text [ ] Phone

Name _____ **Date** _____

Address _____

Age _____ Gender _____ **Email** _____

Cell phone _____ Ok for AKCI to text message? [ ] Yes [ ] No **Prefer [ ] Email [ ] Text [ ] Phone**

Emergency contact

Name and Relation to you, _____ Phone_____

* * * *

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) _____ How well do you manage stress (1=very poor 10=very well) _____

Stress Relievers _____

Mood stability? [ ] Poor [ ] Fair [ ] Good [ ] Excellent

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? _____

Who are your strongest sources of support? _____

Personal strengths _____

Personal areas for improvement _____

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

Past or present criminal activity/charges? _____

* * * *

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

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

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	Erection difficulty	Multiple partners
Painful intercourse	Rape/Sexual abuse	Sexual practices (BDSM, Kink, etc.)	Gender or Sexuality
Non-traditional relationship(s)	LGBTQ	Communication/Conflict in intimate relationships	Sexually transmitted disease(s)
Lack of partner	Virginity	Never had orgasm	Obsessions/Compulsions
Other			

Guidelines

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

____ TEXT ME as soon as you know you cannot attend your appointment. 608.567.4648. Notification via email or phone is acceptable but I will receive a text quickest. You are subject to full-rate charge if notice is less than 72 hours (3 days) or if you are a no-show.

____ Appointments are typically between 60 and 90 minutes. **Please indicate at the start of a session if you have a time restriction.** If both our schedules allow, we can go beyond scheduled time.

____ You agree to rates posted on AKCounselingMadison.com/Rates.

____ **Payment is due at the end of each session** via major credit card, cash, check, or HSA/FSA card.

____ In a public setting, I will not initiate communication in order to preserve confidentiality.

____ Electronic communication (e.g. email, text, video conferencing, etc.) is not 100% secure. You acknowledge these are not HIPAA-compliant formats and therefore risk a confidentiality breach, and you agree not to hold AKCI/Alison Kilkelly, LCSW liable. If you communicate or receive counseling/coaching services with Alison Kilkelly, LCSW via electronic communication you waive all rights to privacy and waive all liability of Alison Kilkelly, LCSW and AK Counseling, Inc. You can request a HIPAA-compliant video-conferencing service be used.

Maximize your therapeutic experience

The topics you are here to discuss may be difficult, 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 and I can initiate dialogue. Let me know if there are other ways to address your comfort.

Please provide feedback (verbal or written) about your experiences in our sessions so adjustments can be made to maximize your therapeutic benefit.

I have read, understand and agree to all of the above statements.

_____ _____ _____

Printed name Signature Date

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

AK Counseling, Inc. is 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).

I have read and understand the above information.

_____ _____ _____

Printed name Signature Date

Your initial appointment is reserved only after a $100 deposit has been made at AKCounselingMadison.com/GetStarted

This is put toward your first session fee or is refundable if you cancel/reschedule 72+ hours prior to your scheduled appointment.

Your card will be charged the full-session rate in the event of a late cancel (less than 72-hours notice) or a no-show.

Below is your credit card information (16-digit credit card number, expiration date, 3-digit security code, and billing zip code) that you allow to be stored in your confidential AKCI file.

You agree to update Alison with any credit card information changes.

CC # _____

Exp _____ 3-Digit Code _____

Billing Zip Code _____

Email _____

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.

_____ _____ _____

Printed name Signature Date