PAMELA KING THERAPY

1015 Central Parkway North, Suite 145 San Antonio, TX 78232 210-885-5009

INTAKE FORM

PLEASE PRINT!

# \*\*\*CONFIDENTIAL INFORMATION\*\*\*

INSTRUCTIONS: Print a copy of this form, sign it, and bring it with you to the counseling session.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Last First Birth date Age

Ethnicity (circle one): Caucasian Hispanic African American Middle Eastern Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Street City State Zip

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Mobile

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years of school

Special training(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Combat: \_\_\_\_\_\_\_\_\_\_\_\_

Marital status (circle one): Single Married Divorced Separated Widowed

SO’s Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Significant Other(SO): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone

Years Married/Together: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s/SO’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s/SO Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s/SO’s special training(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s/SO’s military history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Combat: \_\_\_\_\_\_\_\_\_\_\_\_

Previous Marriages/Serious Relationships

Spouse/SO’s Name # of children from Relationship Length of relationship Reason for divorce/end

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Your Children: Name M/F Age Does the child Is the child a result of live with you? current relationship?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

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Who else, if anyone, shares your residence.

Name Relationship Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

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18. Your Family of Origin (your parents and your siblings):

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Their Relationship to you | Age (if Living) | Additional information (Age and Year of Death, Married, City of Residence, Quality of Relationship |
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Spiritual Faith or Participation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like your spiritual beliefs to be a part of the counseling? Yes No

General physical and mental health:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illnesses/disabilities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Psychiatrist/Psychologist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous counseling (Circle one): Yes No

If yes, give reason(s) for previous counseling/therapy:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Was your counseling experience a positive one? \_\_\_\_\_\_\_ Why or why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |
| --- | --- |
| Therapist | Therapist |
| Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dates of | Dates of |
| Counseling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Counseling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Support System and Coping Skills \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please indicate which of the following are concerning you at this time (check all that apply):

\_\_\_ Alcohol/Substance abuse by self \_\_\_Family Problems \_\_\_ Eating Disorders

\_\_\_ Alcohol/Substance Abuse by others \_\_\_ Marital/Relational Problems \_\_\_ Poor appetite

\_\_\_ Sexual Difficulties \_\_\_ Hopelessness, Helplessness \_\_\_ Fatigue

\_\_\_ Sexual Addiction \_\_\_ Guilt, Worthlessness \_\_\_ Muscle Twitching

\_\_\_ Physical Abuse \_\_\_ Restlessness \_\_\_ Chest Pain

\_\_\_ Emotional Abuse \_\_\_ Crying Spells \_\_\_ Shortness of Breath

\_\_\_ Sexual Abuse \_\_\_ Sudden weight gain/loss \_\_\_ Excessive Sweating

\_\_\_ Anxiety \_\_\_ Insomnia \_\_\_ Muscle Aches

\_\_\_ Thoughts of Suicide \_\_\_Excessive Sleeping \_\_\_Panic Attacks

\_\_\_ Grief \_\_\_ Decreased Concentration \_\_\_ Dizziness/Faintness

\_\_\_ Illness \_\_\_ Loss of interests \_\_\_ Digestive Problems

\_\_\_ Spiritual Problems \_\_\_ Racing Thoughts \_\_\_ Rapid/Pounding pulse

\_\_\_ Adjustments to life changes \_\_\_ Uncontrollable thoughts \_\_\_ Numbness in fingers

\_\_\_ Work, Vocational Problems \_\_\_ Uncontrollable behaviors \_\_\_ Cold Hands

\_\_\_ Criminal Problems \_\_\_ Anger \_\_\_ Excessive Sweating

\_\_\_ Financial Problems \_\_\_ Irritability \_\_\_ Dry Mouth

\_\_\_ Abortion \_\_\_ Miscarriages \_\_\_ Mood Changes

\_\_\_ Anti-Social Behavior/Withdrawing \_\_\_ Fear of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10, please rate the overall severity of your situation with 10 being the most severe: \_\_\_\_\_\_\_\_

Please check how often the following occur to you:

Life is hopeless. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I am lonely. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

No one cares about me. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently I am a failure. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

Most people don’t like me. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I want to hurt someone. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I am so stupid. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I am so depressed. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

God is disappointed with me. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I am disappointed with God. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I can’t be forgiven. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

Why am I so different? \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I can’t do anything right. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I am out of control. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

I am unlovable. \_\_\_ Never \_\_\_ Rarely \_\_\_ Sometimes \_\_\_ Frequently

Check how you generally get along with other people:

\_\_\_ Affectionate \_\_\_ Aggressive \_\_\_ Avoidant \_\_\_ Fight/Argue often

\_\_\_Follower \_\_\_ Friendly \_\_\_ Leader \_\_\_ Outgoing

\_\_\_ Shy/Withdrawn \_\_\_ Submissive \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State the main reason you are seeking counseling at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long have you been experiencing this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a reoccurring problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has it been since the last occurrence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Goal for counseling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PAYMENT AGREEMENT

I agree to the following payment plan to cover my portion of the charges:

\_\_\_\_\_\_\_\_\_\_ I do not have insurance and will pay in full at the time of service.

\_\_\_\_\_\_\_\_\_\_ I will file my own insurance and will pay in full at time of service.

\_\_\_\_\_\_\_\_\_\_ Please file my insurance. I will pay my cost share at the time of service.

\_\_\_\_\_\_\_\_\_\_ I understand that charges for missed appointments are my payment responsibility and are not covered by insurance.

Initial Visit: $130.00 / 60 minutes

Individual, Couples, Family Therapy: $110.00 / 60 minutes

Missed appointments: $60.00

Letter or Report Preparation: $90.00/hr, 1 hour minimum

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Signature Date