Office use only

ID#

Kenneth Cole, PsyD

Doctor of Psychology

ADULT Client Information

Today's Date: _____ Referred By: _____

Client's Personal Information

Name: Last _____ First _____ Middle _____

Address:_____ City: _____ State: _____ Zip: _____

DOB: ____/___/____ Age: ___ Social Security Number: _____/_____/_____

Gender: (Please Circle One) Male Female Other

Marital status: Single ___ Married ___ Divorced ___ Widowed ___ Separated ___ Cohabitating ___

Highest grade of education completed: _____

I give my permission to be contacted at the following numbers/emails regarding appointments:

Home: _____ Work: _____ Ext: _____

Cell: _____ Email: _____

May we leave messages? (Please circle all that apply) Home Work Cell Email

Employer : _____ Ph # _____

Occupation: _____

Person Completing Form:_____ ___ Relationship: ___ _____

Primary Language Spoken in Home:_____

Current Diagnoses: _____

Reason for Referral: _____

Are you Vision or Hearing Impaired? Y _____ N _____ If yes, (Please Specify) _____

_____

_____

Emergency Contacts: Who can we contact in case of an emergency?

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Family Information: Who lives in the home?

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age_____ Relationship _____

Name _____ Age _____ Relationship _____

Ethnic/Cultural Information

Are there any Religious or Spiritual Affiliations? Yes ____ No ____

If Yes, How might this affect your treatment experience? _____

_____

Are there any cultural factors of consideration that may impact your treatment? Yes _____ No ____

If Yes, Please describe: _____

_____

_____

Reason for Treatment

Reason you are currently seeking services: _____

_____

_____

What difficulties are you experiencing? (Please describe any emotional, medical, occupational, educational, social, relationship, parenting etc… _____

_____

_____

How have these difficulties changed over time? (Worsened, stayed the same, improved)?

_____

_____

What are your greatest concerns about your functioning? _____

_____

_____

What goals do you have for assessment and/or treatment? _____

_____

_____

Medical History

Name of Primary care physician _____

Address _____ Phone # _____

Current Medical Problems _____

Current Medications/Dosage _____

Have you ever been hospitalized for mental health? Yes _____ No _____ (If yes, please explain) _____

_____

Is there a history of any family mental health (Diagnosed or Undiagnosed?) Yes ____ No ____ (If yes, please explain) _____

Acknowledgement of Office Policies, Privacy Practices, Consent for Treatment & Payment Responsibility

I have received a copy and had the opportunity to review the Office Policies, Electronic Communications Policy, Client Rights, and Privacy Practices provided to me by Kenneth Cole, PsyD. I have had the opportunity to have answered any questions I might have about these policies.

I give my permission for Kenneth Cole, PsyD to provide treatment to me (13 years and older) or my child. If I am 13 or older, I understand that I have a right to seek and consent to outpatient mental health treatment without a guardian (according to Washington law, RCW 71.34.530). However, I also understand that regular parent/guardian involvement is an important part of my treatment.

I have read and understand the information contained in this form. I certify that the information I provided is correct to the best of my knowledge and I acknowledge that I am responsible for payment of the services rendered by Kenneth Cole, PsyD. I understand that payments are due at the time of services. I authorize Kenneth Cole, PsyD and his administrative and billing staff and/or any collection agencies used by Kenneth Cole, PsyD, to contact me by phone and/or mail for billing activities.

_____ _____

Client Signature (if 13 years old or above) Date

_____ _____

Parent/Guardian Signature (for all minors) Date