Robinson-Kyles Counseling and Testing Services

**Phone: 863-398-6748**

**1604 E. Gary Rd. - Lakeland, Fl 33801**

**Fax: 863-688-3159**

**110 W. 7th St. – Lakeland Fl 33805**

**Fax: 863-213-4010**

**Today you will be seeing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adult (age 18 +)**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Highest level of education \_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_ female \_\_\_\_\_\_male**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency contact information**

**First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ middle\_\_\_\_\_\_\_\_\_ last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(If Applicable)**

**Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Copay Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about this service?**

**Psychology Today Website\_\_\_\_ Friend\_\_\_\_\_**

**Other(please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This counseling center offers therapy groups (anxiety, depression, etc). Are you interested in joining a group? Yes or No**

**Please describe your reason for seeking services.**

**On what date did the issue/incident begin?**

1. **What were the circumstances surrounding the start of the issue?**

**Race/ Ethnicity (please circle):**

**African-American / black American Indian or Alaskan Native Asian American / Asian**

**Hispanic / Latino/a Native Hawaiian or Pacific Islander Multi-racial white**

**Self-identify(please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Religious or spiritual preferences (please circle):**

**Agnostic Atheist Buddhist Christian**

**Hindu Jewish Muslim**

**No preference Prefer not to answer**

**Self-identify (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are there any diagnosed disabilities**

* **Yes If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your occupation/place of employment?**

**What is the average number of hours you work per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?**

**How would you describe your financial situation right now?**

**How many people live with you and what are their relationship to you?**

**On average, how many hours per day do you spend on the internet**

**Relationship status**

**Single Dating/ committed relationship civil union married**

**Separated divorced widowed**

**Approximately how many significant romantic relationships have you had?**

**Do you have any children? Yes\_\_\_\_\_\_\_, No\_\_\_\_\_\_\_**

**If yes, what are their ages?**

**Do you have friends? If yes, how often do you talk to your friends about your problems?**

**Do you have any hobbies? If yes, what are they and how often do you engage in them?**

**Did you have behavioral issues at home or at school when you were a child? Please explain.**

**Please list your mental health conditions.**

**Have you ever attended counseling for mental health concerns? When and for how many sessions?**

**Have you ever served in the military?**

1. **If so what branch did you serve in?**
2. **How long were you in the military**
3. **Reason for leaving the military? Please explain.**

**Did your military experiences include any traumatic or highly stressful experiences which continue to bother you**

* **Yes**
* **No**

**Have you had any previous evaluations or treatment for mental health concerns? If so, please list the dates and places of treatment.**

**Date of treatment Place of treatment Reason and Response to treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been hospitalized for mental health concerns? If so, please list the dates and places of treatment.**

**Date of treatment Place of treatment Reason and Response to treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever seen or heard things that other people have not seen or heard? If yes please explain.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had thoughts of hurting or killing yourself?**

**Please list dates of suicide attempts if applicable:**

**Dates**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you injured yourself without suicide intent? How many times/how frequently?**

**Have you intentionally caused physical injury to another person? How many times/how frequently?**

**Has someone had sexual contact with you without your consent? (e.g. you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threaten or physically forced) How many times/ how frequently?**

**Have you experienced harassing, controlling, and/or abusive behavior from another person? (e.g. friend, family member, partner, or authority figure) How many times/ how frequently?**

**Have you experienced a traumatic event that caused you to feel intense fear, helplessness, or horror? How many times/ how frequently?**

**Please circle those that apply:**

**childhood physical abuse, childhood sexual abuse, childhood emotional abuse,**

**physical attack, sexual violence, militarycombator war zone experience,**

**kidnapped or taken hostage, serious accident, terrorist attack,**

**near drowning, diagnosed with life threatening illness,**

**natural disaster, imprisonment or torture, animal attack,**

**Other\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there a family history of mental illness? If so, please describe their relationship to you (e.g. mother, father, aunt, uncle, etc.) and the condition.**

**Do you have any legal history (lawsuits, DCF incidents, child removals, arrests, DUIs, domestic violence incidents, etc)? Please explain and give dates, charges and reasons for each incident.**

**-If legal case is recent, what are the details of your case plan or probation requirements?**

**-If legal case is recent, do you feel at fault or have remorse for the incident? Please explain.**

**-Is there anything you can do to prevent additional incidents in the future? Please explain.**

**Do you have any medical problems or physical symptoms? \_\_\_\_. Any history of major illnesses, injuries, surgeries; please explain?**

**How many times per week do you exercise and for how long?**

**Please list the medications you are currently taking.**

**Medications Response to treatment Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever abused substances?**

1. **If so, what substances have you abused? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **During what time span (ages) were the substance abused? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Any treatment for substance abuse?**

**Date of treatment Response to treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How would you describe your sleep?**

**How would you describe your appetite?**

**Have you engaged in experienced the following behaviors? Circle all that apply:**

**Eating less Eating more Bingeing Restricting Purging/Vomiting**

**Use of laxatives Use of diet pills/medications Use of diuretics**

**Significant weight gain(last 2 months) Significant weight loss (last 2 months)**

**Use of diet pills/medication**

**Please describe the family history of medical problems (such as stroke, diabetes, cancer, high blood pressure, etc.)**

**How do you handle activities of daily living, such as dressing, showering, brushing your teeth, and overall taking care of yourself?**

**Please circle the frequency that the following has occurred: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Never Less than monthly Monthly Weekly Daily**

1. **Feeling Sad**  **0 1 2 3 4**
2. **Crying**  **0 1 2 3 4**
3. **Over-eating 0 1 2 3 4**
4. **Not eating 0 1 2 3 4**
5. **Sleep for 8 hours & still sleepy** **0 1 2 3 4**
6. **Not slept for 24 hours & not sleepy 0 1 2 3 4**
7. **Feeling irritable 0 1 2 3 4**
8. **Feeling worried 0 1 2 3 4**
9. **Panic attacks 0 1 2 3 4**
10. **Impulsive (inpatient, make quick decisions) 0 1 2 3 4**
11. **Racing thoughts 0 1 2 3 4**
12. **Low energy 0 1 2 3 4**
13. **Aches and Pains 0 1 2 3 4**
14. **Feelings of guilt or hopelessness 0 1 2 3 4**
15. **Feelings of worthlessness 0 1 2 3 4**
16. **Feeling overwhelmed 0 1 2 3 4**
17. **Difficulty concentrating 0 1 2 3 4**
18. **Wanting to be alone 0 1 2 3 4**
19. **Thoughts of death or suicide 0 1 2 3 4**
20. **Drink alcohol or use substances 0 1 2 3 4**
21. **Intrusive thoughts or flashbacks 0 1 2 3 4**
22. **Visual or audio hallucinations 0 1 2 3 4**

**(seeing or hearing things that others do not)**

1. **Homicidal thoughts 0 1 2 3 4**
2. **Nightmares 0 1 2 3 4**
3. **Arguing with others 0 1 2 3 4**
4. **Have you been hospitalized over the last 7 days? Yes No**

**ROBINSON-KYLES COUNSELING AND TESTING SERVICES LLC**

**Consent and Agreement Form for Psychological Testing, Evaluation and Counseling**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow Robinson-Kyles Counseling and Testing Services to perform the following services of psychotherapy, testing, report writing, and consultation with other professionals:

This agreement concerns ❑  myself or ❑   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the practitioner’s time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, and any other activities to support these services. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment for these services.

I also understand the practitioner agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests’ manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a secure place to maintain their confidentiality.

I agree to help as much as I can, by supplying full answers, providing records, making an honest effort, and working as best I can to make sure that the findings are accurate and that counseling is helpful.

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

Signature of client (or parent/guardian) Date

Robinson-Kyles Counseling and Testing Services LLC

Jeanene Robinson Kyles, PhD

Supervising Psychologist

863-398-6748 (Main Lakeland Office)

Your rights regarding your health information:

1. You can ask that we communicate with you in a way or at a certain place that is more private for you. For example, you can ask to receive calls at home, and not at work, to schedule or cancel an appointment.
2. You can ask to limit what is told to people involved in your care or the payment for your care, such as family members or friends.
3. You have the right to look at the health information about you, such as your medical and billing records. You can get a copy of these records, but there will be a charge for it.
4. If you believe that the information in your records is incorrect or missing something important, you can ask to make additions to your records to correct the situation. You must make this request in writing and you must also discuss the reasons you want to make the changes.
5. You have the right to a copy of this notice. If this notice is changed, you will receive a new version.
6. You have the right to file a complaint if you believe your privacy rights have been violated. Also, you may have other rights that are granted to you by the laws of our state and these may be the same as or different from the rights described above. These situations can be discussed with you now or as they arise.

IN CASE OF EMERGENCY

1. IN CASE OF EMERGENCY PLEASE CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM.
2. YOU MAY ALSO CALL THE SUICIDE HOTLINE 1-877-822-5205
3. National Suicide Prevention Lifeline 1-800- 273-8255