Ohio Psychotherapy and Consultation Services, LLC

Shawn D. King, Ph.D., MScM, MSW, LISW-SUPV

Initial Intake Questionnaire

If you are in crisis or having suicidal thoughts, please call 911 or go to the nearest ER.

Welcome!

Thank you for considering me as your therapist. I appreciate it. Since I am in private practice, I only have so many appointment times available on an on-going basis, but I do everything I can to accept as many clients as I can. I have many weekly calls from people wanting to start therapy. My policy is to have potential clients fill out this form and either upload it back to my health portal (if you received this through the health portal), or you can fax the completed form to my confidential fax, or mail it through the regular mail.

Within two business days, and upon review and verification of your insurance and reason(s) for seeking therapy, I will call you back to discuss whether we both want to proceed with making the intake appointment.

Please complete the following information and send it back the way you find most comfortable and convenient. **You may either email it to me at shawn@ohiopcs.com, or fax it to me at 740-589-5701, or mail it to me at 507 Richland Avenue, Suite 203A, Athens, Ohio 45701-3700. Only if you are already been set up for the health portal will you upload this completed form back to the health portal.** I look forward to receiving your information and starting the process.

Please provide the following information:

Full Name: Date of Birth:

Street Address: City State and Zip:

Cell Phone Number: Is it okay to call you and leave messages? Y N

Email address: Is it okay to email you at this email address? Y N

Have you been referred by another health care professional? Y N

If so, by whom? (List name of primary care physician, Nurse Practitioner or other):

Name of Professional:

Address: City State and Zip:

Phone number:

Have you been referred by an Employee Assistance Program? Y N

If so, what is the name of the EAP company?

The EAP address:

The EAP Phone number:

Your EAP Authorization number: Approved for how many sessions:

What is the name of your insurance company?

Insurance Member ID:

800 Number on back of Insurance card for providers and/or behavioral health:

If your insurance is carried by another family member as Primary I need that persons -

Full Name:

Date of Birth:

Street Address:

City, State, Zip:

and Phone number:

Do you have any prior mental health diagnos(es)? Y or N (If yes, please list)

Briefly, what are the areas you are wanting to work on in Therapy?

Do you have any current legal issues and/or, are you currently on parole or probation (please briefly describe)?