Jeffrey Kisling, Ph.D., MFT
7901 168th Avenue NE, Suite 101
Redmond, Washington 98052
tel 425.247.1880 email dr.kisling@drjeffkisling.com

Please read and complete all pages. All information is held in strict confidence. Please contact me with any questions or concerns.

Personal Information

Name_____Birthdate_____Age_____

Street/City/ZIP_____

Home Phone (_____)_____Cell Phone (_____)_____ Gender ☐ M ☐ F ☐ T

SSN_____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Email_____Occupation_____

Employer/School_____

Employer/School Address_____

Family Information

Spouse/Partner_____Birthdate_____Age_____

Street/City/ZIP_____

Home Phone (_____)_____Cell Phone (_____)_____ Gender ☐ M ☐ F ☐ T

Email_____Occupation_____

Employer/School_____

Employer/School Address_____

Child_____Age/Grade_____

Child_____Age/Grade_____

Child_____Age/Grade_____

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name_____Home Phone_____Relation_____

Address_____Work Phone_____

Referral Information

Referred by_____Phone_____

I/We give consent for you to contact the person who referred me/us, to acknowledge an initial consultation. ☐ Yes ☐ No

Signature/Date_____ Signature/Date_____

Please do not bring children with you unless they are specifically involved in psychotherapy.
Please turn off your electronic devices while in waiting room and during your therapy session.

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WELCOME. LET'S GET STARTED.

Please answer the following questions. All answers are confidential. Please feel free to use additional paper if needed.

1. What prompted you to seek counseling? Be specific. _____

_____

2. Describe the problem(s) that you are experiencing associated with the above. _____

_____

3. How long have you had the problem(s)? _____

_____

4. Have things gotten worse, better, or stayed the same since it started? In what way? _____

_____

5. What is the longest period of remission and/or relief that you have experienced? _____

_____

6. In your opinion, what do you think is the cause of your problem? _____

_____

7. Have you attempted to solve this on your own? If so, how? _____

_____

8. State the names of the professional people you have consulted about this. Please include dates: _____

_____

9a. Are you feeling suicidal? ☐ Yes ☐ No

9b. Have you ever felt suicidal? ☐ Yes ☐ No

10a. Are you feeling homicidal? ☐ Yes ☐ No

10b. Have you ever purposefully hurt someone? ☐ Yes ☐ No

11a. Do you feel like doing self-harm? ☐ Yes ☐ No

11b. Have you ever done self-harm? ☐ Yes ☐ No

12a. Do you make friends easily? ☐ Yes ☐ No

12b. Do you keep friends easily? ☐ Yes ☐ No

13. Please list any medications you are taking, if any. Please indicate dosage _____

_____

14. In your own words, how would you like to be helped?_____

_____

_____

_____

_____

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Confidentiality Disclosure: Short Form

Please read carefully and sign. This explains confidentiality for our first meeting. Please feel welcome to ask any questions.

Limits. All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your expressed verbal or written permission, except in instances when disclosure is required by law.

When law requires disclosure. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child or elder abuse or neglect; where a client presents a danger to himself/herself, to others, to property, or is gravely disabled. The Patriot Act of 2001 requires therapists to provide information upon the request of certain federal agencies, and prohibits the therapist from disclosing that any information was sought or obtained.

When disclosure may be required. Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain your psychotherapy records and/or my testimony as your therapist. If there is an emergency during our work together, or in the future after termination where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I am obligated to do whatever I can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

Health insurance disclosures. Please note that disclosure of confidential information may be required by your health insurance carrier (HMO/PPO/MCO/EAP, etc.) in order to process any claims. Only the minimum necessary information will be communicated to the carrier. As your therapist, I have no control or knowledge over what insurance companies do with the information submitted. It is important for you to be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future capacity to obtain health or life insurance or even a job. The risk comes from the fact that mental health information is likely to be entered into the computer of an insurance company, and that information is likely to be reported to the National Medical Data Bank. Accessibility to computers or the National Medical Data Bank is always in question, as computers are inherently vulnerable to unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

Clinical treatment. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. As your therapist, I will use my clinical judgment when revealing such information.

Records. I keep only abbreviated records that note when you have met with me, along with a brief summary of session topics and interventions. If you prefer no treatment records to be kept, you must submit to me a written request to that effect. Once received, I will place your request in your file and retain only the following information: your name, your psychotherapy services agreement, session date(s) and fee for service. I retain clinical records only as long as is mandated by law and the standards of the profession.

Your right to review records. As a client you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case I may provide the records to an appropriate and legitimate mental health professional of your choice. Considering all the above exclusions, if it is still appropriate, upon your request I will release information to any agency/person you specify, unless I assess that releasing such information might be harmful in any way to you or another person.

The Following is Required Information Under RCW 18.19.060

"Counselors practicing counseling for a fee must be registered or licensed with the Department of Licensing for the protection of public health and safety. Registrations of an individual under this chapter does not include a recognition of any practice stands, nor necessarily imply the effectiveness of any treatment." It is your responsibility to elect a provider best suited to your needs. If at any time you believe that I have acted unprofessionally or unethically, I invite you to bring the matter to my attention. If you feel the matter remains unresolved, your complaint may also be addressed to the Washington State Department of Licensing, P.O. Box 9012, Olympia, WA 98504-8001.

I/We the undersigned have read the above carefully and hereby agree to the terms therein.

_____ client name (please print)

_____ client name (please print)

_____

_____