Caring Counseling Services

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6306 Kenwood Avenue

Dallas, Texas 75214

PATIENT INFORMATION

Home Phone: _____

Date: _____ Work Phone: _____

Cell Phone: _____

eMail: _____

Name: _____ _____
Last First Middle Preferred Name

Address: _____

City: _____ State:_____ Zip: _____

Social Security Number:_____-_____-_____ Driver's License Number: _____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D _____

Occupation: _____

Employer: _____

Employer's Address: _____

Name of Spouse / Significant Other: _____Years Together:_____

Spouse's Occupation: _____ Spouse's Employer: _____

Spouse's Employer Address: _____

Names and Ages of Children: _____

_____

Name of Nearest Relative: _____Phone: _____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

Doctor's Address: _____

Doctor's Phone Number: _____

Patient Name _____ Date _____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Grief and Loss:
__ Other. List:
__ HIV Positive

History of Physical, Sexual, Emotional or Verbal Abuse: ____ Yes ____ No If yes, describe: _____

_____

_____

_____

Previous Counseling: _____ Yes _____ No, if Yes give Place, Dates, and Duration: _____

_____

Have you had any major illness, hospitalizations or surgeries? _____ Yes _____ No

Women, please include information about childbirth (include dates): _____

_____

_____

Have you been treated for any health condition by a physician in the last year?____ Yes____ No

If yes, describe: _____

_____

What medications or drugs are you taking? (List name and dosage) _____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____

Do you use any tobacco products?_____ Do you smoke?____ If so, packs per day: _____

Do you take vitamin supplements?_____ If so, please list:_____

Do you consume caffeine?_____ If so, how much per day:_____

Do you exercise?_____ If yes, what is the frequency and type of exercise? _____

Do you sleep well at night? _____ If no, why not? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

Patient Name _____ Date _____

FAMILY HISTORY:

Parents:

Father: living ___ deceased ____ (check one) Current age if still living:_____

Cause of death and age at death if deceased: _____

Mother: living ___ deceased ____ (check one) Current age if still living:_____

Cause of death and age at death if deceased: _____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list:

_____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Anxiety	_____	Eating Disorder	_____
Depression	_____	Post Traumatic Stress Disorder	_____
Anger	_____	Adoption Issues	_____
Abandonment	_____	Other. List:	_____
Alcoholism	_____	Other. List:	_____
Drug Addiction	_____	HIV Positive	_____

INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case**:**

___ Major Medical ___ Medicaid ___ Medicare ___ Medical Savings Account or Flex Plan __ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient Name _____ Date _____

PRESENTING PROBLEM:

Reason(s) for seeking counseling: _____

_____

_____

_____

_____

_____

_____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

_____

_____

1. What is your major concern? _____

   Other concerns: _____

2. If this is a recurrence, when was the first time you noticed this problem?_____

   How did it originally occur?_____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? _____

   _____

3. How frequent is the condition? Constant _____ Intermittent ____

   What causes the problem to come on/get worse?_____

   _____

4. Are there any other conditions you would like to discuss?

   Yes _____ No _____. If yes, describe: _____

   _____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

   _____

5. Is there anything you can do to relieve your major problem? Yes ___ No ___. If yes, describe:

   _____

   If no, what have you tried to do that has not helped?_____

6. What makes the problem worse? _____

   _____

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

Please place an "X" on the line above to indicate level of problem.

Client's Signature _____ Date _____