# Caring Counseling Services

**Souad Shrime M.S., L.P.C., N.C.C**
**6306 Kenwood Avenue**
**Dallas, Texas 75214**

## PATIENT INFORMATION

Date: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

Name: _____
Last First Middle Preferred Name

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ DOB: _____ Marital Status: _____

Occupation: _____

Employer: _____

Employer's Address: _____

Name of Spouse / Significant Other: _____ Years Together: _____

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

Spouse's Employer Address: _____

Name and Ages of Children: _____

_____

Names of Nearest Relative: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

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 | ☐ Pornography Addiction |
| ☐ Depression | ☐ Eating Disorder |
| ☐ Anger | ☐ Post-Traumatic Stress Disorder |
| ☐ Abandonment | ☐ Adoption Issues |
| ☐ Alcoholism | ☐ Grief and Loss |
| ☐ Drug Addiction | ☐ Other – List:_____ |

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

_____

_____

_____

Previous Counseling: ☐ Yes ☐ No – If Yes, give Place, Dates, and Duration:_____

_____

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? ☐ Y ☐ N – If so, how much per week?_____

Do you use any tobacco products? ☐ Y ☐ N Do you smoke? ☐ Y ☐ N – If so, packs per day: _____

Do you take vitamin supplements? ☐ Y ☐ N – If so, please list: _____

_____

Do you consume caffeine? ☐ Y ☐ N – If so, how much per day: _____

Do you exercise? ☐ Y ☐ N – If yes, what is the frequency and type of exercise? _____

Do you sleep well at night? ☐ Y ☐ N – 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 | _____ | Pornography Addiction | _____ |
| Depression | _____ | Eating Disorder | _____ |
| Anger | _____ | Post-Traumatic Stress Disorder | _____ |
| Abandonment | _____ | Adoption Issues | _____ |
| Alcoholism | _____ | Other. List: | _____ |
| Drug Addiction | _____ | Other. List: | _____ |

## 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 Insurance Company: _____

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?_____

   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:

   _____

5. Are there any other unrelated health problems? ☐ Yes ☐ No – If Yes, describe:

   _____

6. Additional Comments:

_____

_____

_____

_____

_____

_____

_____

Client's Signature_____ Date_____