KoKoRo Counseling & Integrated Health Services

Counseling, Healthy-Living & Wellness Coaching, Biofeedback Training

P.O. Box 70494 Houston, TX 77270 PH: 832.632.8118 yourwellbeingmatters@gmail.com

(Fax/Upload completed form to 713.422.2428 & notify office. Must send to reserve your 1st appointment)

Patient / Client Information Sheet

Referred By: _____ Today's Date:_____
Referred or seeking service for presenting issue of _____

Printed Name: _____ Gender: _____ SS#: _____-_____-_____

Date of Birth: _____ Driver's License # & State Issued: _____

Permanent Address: _____ E-mail* _____
City: _____ State: Zip: _____ *May we send emails to you @ above address? Yes / No

Cell*/Home Phone*: _____ Work/Alternate Phone*:_____
*May we ("X" best.) Text/ leave a message @ above PH#? __Yes/__No *May we leave a message @ above PH#? __Yes/__No

Marital Status ("X"best)__single __ engaged __ co-habitating __ partnered __ married __ separated __ divorced __widowed __ other (explain)_____

Occupation: _____ Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____ ("X" best) Employer Referred You?__ Yes__ No
Current legal issues/litigation? __Yes/__No; Current Work-Comp Case? __Yes/__No; Current Disability Case? __ Yes/__No

Primary Care Physician: _____ Phone#: _____
Current Psychiatrist: _____ Phone#: _____

RESPONSIBLE PARTY INFO (If someone other than you will pay for services or is legal guardian for a ward/minor):
Name: _____ Gender: _____ SS#: _____-_____-_____
Relationship to Client: _____ Date of Birth:_____
Address: _____ E-mail* _____
City: _____ State: Zip: _____ May we send emails to named @ above address? Yes/No
Cell/Home Phone: _____ Work/Alternate Phone:_____
May we (X best.) text / leave a message @ above PH#?__ Yes /__ No May we leave a message @ above PH#? __ Yes /__ No
Occupation: _____ Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY
Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone#: _____ Evening Phone#: _____
Work Phone#: _____ Mobile#: _____
Payment of Services: I'll pay for services myself as "Fee for Service" because I do not have benefits. __Yes/__No (Initial:_____)
I'll pay for services myself as "Fee for Service" because I OPT-OUT of using my benefits. __Yes/ __No (Initial:_____)
I authorize Billing/Benefits to KoKoRo Counseling & Integrated Health Services/Headway, as In-network __ Yes/__No (Initial: _)
I'll pay for services/submit claims myself or use ADVEKIT for payment& claims as Out-of-Network __Yes/__No (Initial: _____)
Please complete 'Benefit" Forms (or HEADWAY/ADVEKIT) & Fax back w/ Photo/Copy of Benefit Card & DL, front & back.

My signature below indicates I authorize the release of any medical or other information necessary for processing and payment of services due to KoKoRo Counseling & Integrated Health Services/affiliated provider for the patient above.

Patient Signature: _____ Date: _____
Or Legal Guardian's Signature: _____ Date: _____

_____ BIOPSYCHOSOCIAL HISTORY for Counseling with LA Shields, MS, LPC

(Please complete History before 1st appt for review together in session or upload into MDLIVE if you prefer)

Client name _____ Client ID# _____ Client SS# _____ Date _____ Page ___

CONCERNS & GOALS for COUNSELING: Date:

Presenting problems **Duration** (months) **Additional information**:

_____ _____ _____

_____ _____ _____

My Goal(s) for Therapy: _____

_____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms I'm currently experiencing)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	ethical/spiritual dilema	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid thoughts	[ ]	[ ]	[ ]	[ ]	disassociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	disorganized thoughts	[ ]	[ ]	[ ]	[ ]	excessive physical complaints	[ ]	[ ]	[ ]	[ ]
memory loss	[ ]	[ ]	[ ]	[ ]	suicidal thoughts	[ ]	[ ]	[ ]	[ ]	self-mutilation/cutting	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
difficulty focusing	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	illness/health/ medical concerns	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	anger, arguing	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	defiant behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	low self-esteem	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief, losses	[ ]	[ ]	[ ]	[ ]	headaches	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	addictive behaviors	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

Please circle any of the above symptoms you've experienced previously, which you've either received treatment for or are currently managing successfully. Additional Comments: _____

_____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

origin:

_____

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):

Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

_____

_____

_____

List any known allergies: _____

Is there a history of any of the following in your family of

[ ] tuberculosis [ ] heart disease
[ ] birth defects [ ] high blood pressure
[ ] emotional problems [ ] alcoholism
[ ] behavior problems [ ] drug abuse
[ ] thyroid problems [ ] diabetes
[ ] cancer [ ] Alzheimer's disease/dementia
[ ] mental retardation [ ] stroke
[ ] other chronic or serious health problems _____

_____

Describe any serious hospitalization or accidents:

Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

List any abnormal lab test results:

Date _____ Result _____ Date _____ Result _____

OTHER INFORMATION:

What I like most about myself: _____

_____

I consider my personal strengths as follows: _____

_____

Effective coping strategies I use include: _____

Client name _____ Client ID# _____ Client SS# _____ Date _____ Page ___

BIOPSYCHOSOCIAL HISTORY for Counseling with LA Shields, MS, LPC

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] **Prior outpatient psychotherapy or inpatient treatment for a psychiatric, emotional or substance use disorder?**
No Yes If yes, on _____occasions. Longest treatment by _____ for ____ sessions from ____/_____ to _____/_____
Provider/Facility Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] **Has any family member had outpatient or inpatient treatment for a psychiatric, emotional, or substance use disorder?** If yes,
No Yes who/why (list all):_____

[ ] [ ] **Prior or current psychotropic medication usage?** If yes:
No Yes

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

[ ] [ ] **Has any family member used psychotropic medications?** If yes, who/what/why (list all):_____
No Yes _____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify) _____	[ ]	[ ]	[ ]

Parents' current marital status:
[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:
[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse
[ ] experienced physical/verbal/sexual abuse

Age of emancipation from home: _____ **Circumstances:** _____

Special circumstances in childhood: _____

IMMEDIATE FAMILY

Marital status:
[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ____ years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
_____[ ] _____ prior marriages (partner)

Intimate relationship:
[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:
[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] very dissatisfied with relationship
[ ] dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient

List children not living in same household as client:

Frequency of visitation of above: _____

Describe any past or current significant issues in intimate relationships: _____

Describe any past or current significant issues in other immediate family relationships: _____

Client name _____ Client ID# _____ Client SS# _____ Date _____ Page ___

BIOPSYCHOSOCIAL HISTORY for Counseling with LA Shields, MS, LPC

ADDICTIONS (SUBSTANCES/BEHAVIORS) USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances/Behavior Use:

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol					
[ ] amphetamines/speed					
[ ] barbiturates/downers					
[ ] caffeine					
[ ] cocaine					
[ ] crack cocaine					
[ ] hallucinogens (e.g., LSD)					
[ ] inhalants (e.g., glue, gas)					
[ ] marijuana or hashish					
[ ] nicotine/cigarettes					
[ ] prescription_____					
[ ] gambling_____					
[ ] pornography/sex/internet					
[ ] other_____					

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____
describe:_____

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other _____

DEVELOPMENTAL HISTORY (check all that apply for your history as a child or for a child/adolescent client)

Problems during mother's pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ____lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _____) [ ] lead poising (age _____)
[ ] German measles (age _____) [ ] mumps (age _____)
[ ] red measles (age _____) [ ] diphtheria (age _____)
[ ] rheumatic fever (age _____) [ ] poliomyelitis (age _____)
[ ] whooping cough (age _____) [ ] pneumonia (age _____)
[ ] scarlet fever (age _____) [ ] tuberculosis (age _____)
[ ] autism [ ] mental retardation
[ ] ear infections [ ] asthma
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
_____

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other _____
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other _____

Client name _____ Client ID# _____ Client SS# _____ Date _____ Page ___

BIOPSYCHOSOCIAL HISTORY for Counseling with LA Shields, MS, LPC

Childhood Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other _____

Childhood Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

Current or highest education level _____

Describe any other developmental problems or issues from childhood: _____

SOCIO-ECONOMIC HISTORY (check all that apply for client. Skip if client is child)

Living situation:

[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Employment:

[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: _____

Financial situation:

[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Social support system:

[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Military history:

[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident _____

Legal history:

[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison _____ time(s)
total time served: _____
describe last legal difficulty: _____

Sexual history:

[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _____
[ ] age first pregnancy/fatherhood ___
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age __ to ___
Additional information: _____

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): _____
describe any cultural issues that contribute to current problem: _____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _____

List H.S. Studies/ College Studies / Degrees earned and any significant issues during academic years: _____

List current employment and describe any past or current significant issues in employment/career environment: _____

SOURCES OF DATA PROVIDED ABOVE: [ ] Client self-report for all [ ] A variety of sources (if so, check sources below):

Presenting Problems/Symptoms
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify) _____

Family History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify) _____

Developmental History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify) _____

Emotional/Psychiatric History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify) _____

Medical/Substance Use History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify) _____

Socioeconomic History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify) _____