KoKoRo Counseling & Integrated Health Services

Healthy-Living/Wellness Training, Coaching, Counseling

(Fax completed form to 713.422.2428 & notify office. Fax by Dr. with current DX saves cost of Assessment at Initial Diagnostic Interview Session. Form must be received by second session.)

Dr., Health Professional or Self-Referral Form

Referral Source: _____ Today's Date: _____

Client Printed Name: _____ Symptoms/Concern of referral: _____

Client Address: _____ E-mail: _____

City: _____ State: ____ Zip: _____ May send emails to you at above address? Yes / No

Cell/Home Phone: _____ Work/Alternate Phone: _____

May we VM / text message @ above PH#? Yes / No May we leave a message @ above PH#? Yes / No

Current Problem (If a Dr, please include ICD10 Dx codes, if applicable):

_____

Is condition made worse by Stress: YES / NO; explain _____

Current Top (3) Symptoms Reported/Observed:

_____

Current Medications Prescribed: _____ **Since when:** _____

Any Other Medical Condition(s): _____

Date of last physical or annual health exam:

Dr. Recommends (Check All Appropriate Options) or Client Desires:

- ○ **Counseling / Psychotherapy:** (Client requests and/or Dr. recommends due to observed distress level / medication prescribed)**: (Circle Dr. recommend approach(es)) :**
  - ___**Cognitive Behavioral**
  - ___ **Relaxation/Stress Management Training**
  - ___ **Insight-Oriented**
  - ___**Lifestyle/Change of following Behavior:** _____
  - ___**Symptom-focused Education**
  - ___**Supportive Maintenance**
  - ___**Other:**_____

  for reducing exacerbation of **following medical condition:** _____

  _____

- ○ **Assessment of Stress / Health Risk Profile: ie: High Blood Pressure, Diabetes, Fibromyalgia** Determine Counseling vs. Healthy Living Intervention Training for Preventative Medicine & Risk Factor Reduction and lifestyle behavior modification benefits

- ○ **Biofeedback Training / Behavior-Change / Stress Coping (No**n-Counseling) **circle one** & incude DX-ICD10): Headaches_____, IBS_____, TMJ_____,

Patient Follow-up w/ M.D. in _____#of weeks for review of assessment/ referral:

M.D.'s Signature: _____ **Date:** _____

I authorize the release of this medical/personal information necessary for insurance benefit verification & referral follow-up to affiliated providers of KoKoRo Counseling & Integrated Health Services.

Signature of Client: _____ **Date:** _____

Printed Name of Client: _____ Fax to ATTN: "L.A." 713.422.2428 or Upload at Website