CHRIST-RICE COUNSELING & CONSULTING (CRCC)

Client History and Information

Basic Information:

Date:

Name:

Social Security Number:

Date of Birth:

Gender: [ ] Male [ ] Female [ ] Other

Ethnicity:

Home Address:

Home Phone Number: May we leave a message? [ ] Yes [ ] No

Work Phone Number: May we leave a message? [ ] Yes [ ] No

Mobile Phone Number: May we leave a message? [ ] Yes [ ] No

If the above client is a minor complete the following:

Name of Guardian:

Address of Guardian:

Guardian's Home Phone: May we leave a message? [ ] Yes [ ] No

Guardian's Work Phone: May we leave a message? [ ] Yes [ ] No

Guardian's Mobile Phone: May we leave a message? [ ] Yes [ ] No

If you would like to bill your insurance for your sessions or a portion of the cost, you can request the necessary documentation to submit to your insurance company.

Referral Source

Who referred you to our office, or how did your learn about our practice?

Emergency Contact Information

In case of an emergency, who should we contact?

Name:

Relationship:

Address:

Phone Number:

History Information

Who is providing the history information?

[ ] The patient [ ] The patient's guardian [ ] Other

Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence

[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.

[ ] Depression/Sad/Down feelings

[ ] High/Low energy level

[ ] Angry/Irritable

[ ] Loss of interest in activities

[ ] Difficulty enjoying things

[ ] Crying spells

[ ] Decreased motivation

[ ] Withdrawing from people/Isolation

[ ] Mood Swings

[ ] Black and white thinking/All or nothing thinking

[ ] Negative thinking

[ ] Change in weight or appetite

[ ] Change in sleeping pattern

[ ] Suicidal thoughts or plans/Thoughts of hurting yourself

[ ] Self-harm/Cutting/Burning yourself

[ ] Homicidal thoughts or plans/Thoughts of hurting others

[ ] Poor concentration/Difficulty focusing

[ ] Feelings of hopelessness/Worthlessness

[ ] Feelings of shame or guilt

[ ] Feelings of inadequacy/Low self-esteem

[ ] Anxious/Nervous/Tense feelings

[ ] Panic attacks

[ ] Racing or scrambled thoughts

[ ] Bad or unwanted thoughts

[ ] Flashbacks/Nightmares

[ ] Muscle tensions, aches, etc.

[ ] Hearing voices/Seeing things not there

[ ] Thoughts of running away

[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[ ] Feelings of frustration

[ ] Feelings of being cheated

[ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

[ ] Distorted body image (believe you are heavier or less attractive than others say you are)

[ ] Concerns about dieting

[ ] Feelings of loss of control over eating

[ ] Binge eating/Purging

[ ] Rules about eating/Compensating for eating

[ ] Excessive exercise

[ ] Indecisiveness about career

[ ] Job problems

[ ] Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy? [ ] Yes [ ] No

Additional Information:

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Is there any type of treatment you would like to continue?

Have you had hospital stays for psychological concerns? [ ] Yes [ ] No

Are you currently experiencing thoughts of harming either yourself or someone else?

[ ] Yes [ ] No

Have you in the past experienced thoughts of harming either yourself or someone else?

[ ] Yes [ ] No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? [ ] Yes [ ] No

If yes, explain:

Did you walk, talk, and read on time? [ ] Yes [ ] No

Explain:

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?

Are you satisfied at where you are in your life?

If not, where would you like to be?

Medical History

List any current or important past medications

Medication & Dose: Response to Medication:

History of serious childhood illnesses:

Other health concerns, serious illnesses, conditions, or major operations requiring

hospitalization during your lifetime:

Have you experienced any head injuries? [ ] Yes [ ] No

Important Details:

If yes, did you lose consciousness? [ ] Yes [ ] No

Have you experienced convulsions or seizures? [ ] Yes [ ] No

If yes, did you also have a fever? [ ] Yes [ ] No

Explain any allergies you have:

How would you rate your current physical health?

[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health "check up?"

Do you have a primary care physician? [ ] Yes [ ] No

If yes, complete the following:

Name

Address

Phone Number

Family History

Birth Location:

Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father [ ] Other:

Relationship with parent figures:

(good, fair, poor, close, distant, etc.)

Mother:

Father:

Step-parent:

Other:

List your siblings and describe your relationship with them?

Name

Age

Gender

Nature of Relationship

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

Any family history of substance abuse, mental illness, suicide, or violence?

Any Additional Family Information:

Social History

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

Educational History

When attending school where you:

[ ] In regular classes [ ] Home Study [ ] Special classes [ ] Advanced classes

[ ] Ever suspended [ ] Placed in alternative school

What is the highest educational level you have completed?

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

Occupational History

What is your current employment status?

[ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed [ ] Self-employed

[ ] Student [ ] Other

Are you satisfied with your employment?

If not, why?

Marital History

Which best describes your marital status?

[ ] Married, Date: _____ [ ] Never Married [ ] Widowed, Date: _____

[ ] Separated, Date: _____ [ ] Divorced, Date:_____

If you are married, please briefly describe nature of your marital relationship:

If you are married, which best describes your marital satisfaction?

[ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:

Name

Date

Nature of Relationship

Do you have children? [ ] Yes [ ] No

If yes, complete the following:

First Name

Age

Gender

Nature of Relationship

Are there presently any child custody issues involving you or your family? [ ] Yes [ ] No

Does your family currently have Child Protective Services Involvement? [ ] Yes [ ] No

If yes please complete the following:

Case Worker's Name:

Phone:

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other) [ ] Yes [ ] No

If you answered yes, please complete the following substance abuse history chart.

Substance

Ever Used Yes/No

Age of First Use
Frequency of Use
(Daily, Weekly, Monthly)
Amount Used
How did you use it? (smoked, injected, etc.)
Alcohol
Marijuana
Cocaine or Crack
Heroin
Amphetamines
Club Drugs (Ecstasy, Inhalants, etc.)
Pain Medication (Oxycontin, Vicodin, etc.)
Benzodiazepines
Hallucinogens
Other

Complete the following chart if you have ever received treatment for a substance abuse issue.
Name of Treatment Program
Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)
Date of Treatment (Month, Year)
Outcome (Any Clean time?)

Legal History

Do you currently have any pending criminal charges? [ ] Yes [ ] No
Are you on probation? [ ] Yes [ ] No
Name of Probation Officer and County
Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No:
If yes, complete chart.
List any Arrests/Convictions
Date of Arrests/Convictions

Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)

Additional Information

Summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

Name 5 things you would like to change about yourself.

What are your strengths?

What are your weaknesses?

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

_____ _____

Signature of client or guardian Date

Consent to Treatment

Client Name: _____ DOB: _____ SSN: _____

I, _____, (client/or parent/legal guardian) consent to receive services (consent for myself/my child to receive services) from Christ-Rice Counseling & Consulting beginning _____ (today's date). I understand that payment is due at time of service, as cited in the Agreement, and have been informed clearly of fees and payment policies.

I am aware that the practice of psychotherapy/counseling is not an exact science and as a consequence, I acknowledge that no guarantee has been made to me concerning the result of any evaluation or treatment, which may be rendered.

It is understood that the information obtained during the services provided will remain confidential except as provided by law, and previously described above.

I understand the information presented above in this Informed Consent to Treatment agreement and I have also had an opportunity to review the Christ-Rice Counseling & Consulting office policies and the About the Treatment Process as described in this packet. I have had an opportunity to discuss these materials with my clinician and have questions answered. I voluntarily give my consent to treatment and to be subject to the arrangements presented.

Signature of Client(s) _____Date_____

Signature of Parent/Legal Guardian (if applicable) _____Date_____

In the event of an emergency*, consent is hereby given to contact the following individual

* l) Name_____ Telephone #_____

*If left blank, we will assume we do not have your permission to contact anyone in case of an emergency.

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Christ-Rice Counseling & Consulting's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Deniece Christ-Rice at deniece@christ-ricecounseling.com or 832-910-9599.

_____
Signature of Patient/Client Date

_____
Signature or Parent, Guardian or Personal Representative * Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Patient/Client Refuses to Acknowledge Receipt:

_____
Signature of Staff Member Date

TEXT CONSENT

We may use SMS text messaging for certain types of communication with you, including appointment reminders and information, administrative requests, client services requests and information, etc.

Please initial each section for your consent.

_____ You agree to receive SMS text messages from us, related to services that we are providing to you.

_____ You understand that you can text us STOP at any time to opt out of receiving SMS text messages from us. You can text us HELP at any time to receive help.

_____ Your mobile information will not be shared with any third parties/affiliates for marketing/promotional purposes. All policies are followed as per CTIA guidelines 5.2.1. At any time if you want your information to be removed, you can contact us via our email address or regular mail.

You can contact us for any privacy related queries via our email address or regular mail.
Our email address:
deniece@christ-ricecounseling.com
Our address:
3719 Navigation Blvd., Houston, TX 77003

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date