Las Colinas Counseling Center, P.A
1075 Kinwest Parkway, Ste 107
Irving, TX 75063
Tel: 972-910- 8388 Fax: 972-910-8366
www.lascolinascounseling.com

Client Information

Date: _____Name: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell #: _____
Please indicate where we may leave a message Home: ___ Work:___ Cell: ___ Email: ___
Address: _____City: _____Zip: _____
Date of Birth: _____ Sex: Male: _____ Female: _____ Social Security: _____
Marital Status: Single: ____ Relationship: ____ Married: _____ Separated: ____ Divorced: ____ Widowed: ___
Name of Spouse/Sig other: _____
Children's Name(s) & Age(s): _____
_____
Primary Care Physician: _____ City: _____
Employer: _____
Insurance through Employer: Yes _____ No _____
Medical Insurance Co: _____Policy/Group ID#: _____
Primary Insured's Name & Date of Birth: _____

Emergency Contact

Name: _____ Home Phone: _____
Address: _____Relationship: _____

How did you hear about Las Colinas Counseling Center?: _____

Education (Highest level completed): _____

Health Information

Please rate your health: Very Good ___ Good ___ Average ___ Declining ___

Recent weight changes: Lost _____ Gained _____

Date of Last physical exam: _____Report from most recent exam: _____

List all important past or present injuries, illnesses or disabilities: _____

_____

Are you currently taking any medication? Yes ___ No ___

If yes, please list them with dosages: _____

_____

Prescribed by: _____

Have you ever used drugs for other than prescribed medical purposes? Yes ___ No ___

If yes please list them: _____

Have you ever had a severe emotional upset? If so, please explain: _____

_____

Have you ever terminated a pregnancy? If yes, when? _____

Have you ever had a miscarriage? If yes, when? _____

Religious/Faith Background

Current Faith involvement _____

Please explain any recent changes in your spiritual life_____

Other Information

Are you willing to complete and sign a release of information so your counselor may obtain social, psychiatric, or medical information? Yes ___ No ___

Have you ever been arrested? Yes ___ No ___

If yes, please explain: _____

Have you recently suffered loss from serious personal, social, business, or other reversals? Yes ___ No ___

If yes, please explain: _____

_____

Have you ever been the victim of a crime? Yes ___ No ___

If so, have you filed with Texas Crime Victims Compensation? Yes ___ No ___

Identify any previous marriages: _____

Identify any history of psychiatric/emotional/drug or alcohol problems and treatments in your **current family** and in your **family of origin**: _____

_____

_____

Personality Information

Have you ever had any counseling or therapy before? Yes ___ No ___

Outcome: _____

Please list names/dates of counselors: _____

Have you ever been in a residential or outpatient program for chemical dependency or psychiatric treatment?

Yes ___ No ___

If yes, please list facility, dates, and indicate if you completed the program successfully:

_____

Please circle any of the following words which best describe you now:

Active	Ambitious	Self-confident	Persistent	Nervous
Hardworking	Impatient	Impulsive	Moody	Often blue
Excitable	Imaginative	Calm	Serious	Easy-going
Shy	Good-natured	Introvert	Extrovert	Likable
Leader	Quiet	Stubborn	Submissive	Lonely
Self conscious	Sad	Fatigued	Anxious	Sensitive

Other:_____

Consent

Please READ and INITIAL in the space provided below.

I understand and agree that I am ultimately responsible for co-pays, deductibles, and/or the balance on my account for any professional services rendered. I have also read and received a copy of **CLIENT'S RIGHTS AND INFORMATION**, and I understand the **CANCELLATION** policy. _____ I hereby consent for therapeutic services provided by Las Colinas Counseling Center, and I authorize Las Colinas Counseling Center (and its agents) to release information about me necessary to obtain insurance benefits and/or to receive payment._____ I understand that my signature requests insurance payments to be made and authorize release of information necessary to pay the claim.

_____ _____

Client's Signature Date

_____ _____

Counselor's Signature Date

I attest that I am the legal guardian or managing conservator of this minor child, _____, with rights to consent medical treatment for this minor child and I do hereby consent for counseling services to be provided to this child. Signature of Guardian or Managing Conservator _____ Relationship_____

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Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email or text messaging to remind you of an appointment.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Las Colinas Counseling Center.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (please request revocation form from administrators).

_____ (Patient initials) I understand that I can respond to the email or text message to confirm my appointment. I understand that I cannot respond to the email or text message to cancel my appointment.

_____ (Patient initials) I understand that if I need to cancel I must call the office one day before my scheduled appointment. I understand that failing to respond to the email or text message does not mean my appointment has been cancelled.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders, feedback, information is_____.

I would prefer to have a(n) _____ email or _____ text message appointment reminder.

Patient Name: _____
(print)

Patient/Patient Representative Signature:

_____

Date: _____ Time: _____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Acknowledgement of Receipt of Notice of Privacy Practices

I have receieved the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Printed Name of Patient or Personal Representative