

# OASIS COUNSELING & EDUCATIONAL SERVICES

**8035 E. R L Thornton FWY Suite 334, Dallas, TX 75228; PH: 214-435-6414; FAX: 877-773-9382**

To make our first meeting more productive, please give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

Current Date \_\_\_\_\_

## For Individual Therapy

Client's Name: \_\_\_\_\_ Client's Date of birth: \_\_\_\_\_

Client's Social Security Number: \_\_\_\_\_ Client's Phone #: \_\_\_\_\_

Home # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Individual's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Ins. Member #: \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Subscriber's Name: \_\_\_\_\_ Insurance Subscriber's DOB: \_\_\_\_\_

Insurance Subscriber's Social Security #: \_\_\_\_\_ Insurance Subscriber's Phone #: \_\_\_\_\_

Insurance Subscriber's s Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

EAP Authorization #: \_\_\_\_\_ Auth. Start Date: \_\_\_\_\_ Auth. Expiration Date: \_\_\_\_\_

EAP Program: \_\_\_\_\_ EAP Phone #: \_\_\_\_\_ Number of sessions authorized \_\_\_\_\_

Client's Employer: \_\_\_\_\_ Hire Date \_\_\_\_\_ Position \_\_\_\_\_

Circle last year of school completed: 9 10 11 12 GED College 1 2 3 4 Other \_\_\_\_\_

If full time student, School \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Religion \_\_\_\_\_ Church \_\_\_\_\_ Pastor \_\_\_\_\_

**Marital Status:** Single (Never Married) Engaged Married Living Together (Not Married) Separated Divorced

If married, total number of marriages for you \_\_\_\_\_ For your Spouse \_\_\_\_\_

**List of significant others:** (e.g., Children, brothers, sisters, grandparents, step-relatives, parents, siblings, spouse, etc.):

Child's Name	Age	Sex	Relationship to the individual	Live in the individual home?

### General Symptoms:

Check behaviors and symptoms that occur more often than desired:				
	Aggression (Physical)	Fatigue		Property Destruction
	Aggression (Verbal)	Hallucinations		Phobias/fears
	Anxiety	Hopelessness		Sexual Concerns
	Avoiding People	Impulsivity		Sleeping Problems
	Depression	Irritability		Suicidal Thoughts
	Disorientation	Judgment Errors		Self-Injurious Behaviors
	Distractibility	Loneliness		Withdrawing
	Drug Dependence	Memory Impairment		Other _____
	Eating Disorder	Mood Swings		_____
	Eloping	Panic Attacks		_____

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## Record Request:

Do you want your records to be sent to any person or organization? Yes No

If yes, to where? \_\_\_\_\_

## Medical Information

Primary care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone Number \_\_\_\_\_

## List your current medications:

Medication Name	Prescribing Physician	Dosage	Frequency	Comply	Reason for taking this medication

Have you ever tried to harm yourself? Y / N

If so, when? \_\_\_\_\_ and how? \_\_\_\_\_

Have you ever been hospitalized for any mental illness or substance abuse? Yes No How long ago? \_\_\_\_\_

Reason \_\_\_\_\_ Hospital \_\_\_\_\_ City \_\_\_\_\_

Did you continue with outpatient counseling? Yes No With whom? \_\_\_\_\_

When you have a problem, who is the person you can most talk to about it? \_\_\_\_\_ Relationship? \_\_\_\_\_

## If you have any of the following issues, please describe:

Eating Habits \_\_\_\_\_

Sleep /Rest Patterns: \_\_\_\_\_

Physical Exercise: \_\_\_\_\_

Alcohol: \_\_\_\_\_

Caffeine: \_\_\_\_\_

Smoking: \_\_\_\_\_

Other drugs: \_\_\_\_\_

## Substance Abuse/Chemical Use History

Loss of control

Blackouts

Unable to stop

Tremors

Ulcers

A.M. drinking

Pre-drinking

Use to reduce stress

High Blood Pressure

Nosebleeds

Hiding Supply

Sneaking use

Tolerance

Hepatitis

Gastritis

Prescription abuse

Use to reward self

Guilt or remorse

Seizures

Delirium

Other symptoms, elaborate (including trigger events) \_\_\_\_\_

## Treatment History

Detoxification: \_\_\_\_\_ Outpatient: \_\_\_\_\_ After care: \_\_\_\_\_

Other: \_\_\_\_\_ Inpatient: \_\_\_\_\_ Longest abstinence: \_\_\_\_\_

## Counseling History

Date for last counseling session \_\_\_\_\_ alone with spouse with child/children family

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**Current problem (s) or concern (s):**

Please list current problems and how long you have had the problem (s) or concern (s):

1. \_\_\_\_\_ How long? \_\_\_\_\_
2. \_\_\_\_\_ How long? \_\_\_\_\_
3. \_\_\_\_\_ How long? \_\_\_\_\_
4. \_\_\_\_\_ How long? \_\_\_\_\_

What have you done or are currently doing to resolve the problem (s) or concern (s)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What are your therapy goals?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Are there any sensory or health problems that would impair your ability to make or communicate responsible decisions? Yes / No. If yes, describe in detail.

\_\_\_\_\_

Areas of Strength that you can draw from:

\_\_\_\_\_

Areas of Weakness that need Improvement:

\_\_\_\_\_

Any possible Barrier that may stop you from committing fully to your Treatment:

\_\_\_\_\_

Leisure/Recreational			
Special areas of interest or hobbies (art, books, crafts, physical fitness, sports, outdoor activities, walking, hunting, fishing, bowling, traveling, etc....)			
	Activity	How often now?	How often in the past?
1			
2			
3			

**COUNSELING** is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

<b>Client's Signature</b>	<b>Date</b>
<b>Parent/Guardian Signature, if applicable</b>	<b>Date</b>

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## Disclosure Statement

Thank you for choosing Oasis Counseling and Educational Services for your mental health needs. In order to help you be more comfortable with the counseling process and make informed decisions, your Counselor, Dr. Mary Okafor, has prepared these statements for you to get to know your counselor and her psychotherapy methodologies. Her goal is to provide you with effective counseling and positive outcome(s). She is committed to helping you accomplish your counseling goals. If you have questions or concerns, please do not hesitate to bring them to her attention.

### Education, Training, and Experience of your provider

Dr. Okafor received double Masters Degrees in Counseling and Education from University of North Texas, Denton; and a Doctorate degree in Educational Administration and Counseling from Texas A&M, Commerce Texas. She obtained her License (#15688) in the State of Texas in 1996 and is currently a Licensed Professional Counselor Supervisor. Dr. Okafor acquired additional certifications in Solution Focused Therapy, Critical Incidence Stress Management, Mindfulness Strategies, SASSI administration and scoring (substance abuse), to mention but a few.

### Forms of Psychotherapy Approaches

Dr. Mary Okafor is a solution-focused therapist with over 20 years of experience in individual, family, couple and group counseling. She has an enviable track record with emphasis on treatment for depression, anxiety, critical incident stress management (CISM), anger management, post- traumatic stress disorder (PTSD), addictions (substance, sexual and gambling), grief, communication problems, attention deficit and hyperactivity (ADHD), truancy, and conflict resolution in marital, family, job, and school settings.

Dr. Okafor diligently works to restore wholeness to her clients (body, mind and spirit). She believes that any behavior that is learned can be un-learned; therefore, she challenges her clients to rise to the occasion and take control of their lives. She is passionate about the power of choice, attitude and client empowerment, and utilizes those concepts to create a lasting impact and positive changes in her clients. She currently provides mental health services to twenty-two networks. Her favorite technique in counseling is the Cognitive Behavior therapy (CBT).

Her hobbies include spending quality time with family and friends, listening to music, dancing, and yoga. If you have questions or concerns, please do not hesitate to bring them up.

\_\_\_\_\_  
Signature of person receiving services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian/Responsible Party

\_\_\_\_\_  
Date

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**Confidentiality**

It is our goal to protect your privacy. Your records with us are confidential and will not be disclosed to anyone without your written consent, unless required by law. Below are exceptions to confidentiality:

- 1. When you tell us that you are going to kill or harm yourself or others, we are required by law to ensure your safety and safety of others. In such situation, we will notify legal authorities, potential victims, and family members.
- 2. When you tell us about incidents of abuse such as abuse of a child, elderly, and disabled persons, we are required by law to report it.
- 3. When we are subpoenaed by a court of law, we are required to release your record.

There are other situations confidentiality may not be insured such as listed below:

- 1. In couple or family therapy, we cannot guarantee that your partner or family member will maintain the confidentiality policy.
- 2. For individuals who are minors or under the care of a conservator, your guardian must sign a written consent and can have access to your record.

\_\_\_\_\_  
Signature of person receiving services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian/Responsible Party

\_\_\_\_\_  
Date

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**Consent for Release of Information**

Name: \_\_\_\_\_  
Last First M. I. Authorization/Case #

Social Security Number: \_\_\_\_ -- \_\_\_\_ -- \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize:

**Oasis Counseling & Educational Services**

**8035 E. R L Thornton FWY, Suite 334, Dallas, TX 75228**

To release my mental health record to:

\_\_\_\_\_  
Individual/ Agency/ Organization

\_\_\_\_\_  
Address: Street, City, State and Zip Code

I understand that when the information I requested is given to/or requested from the Individual/Agency/Organization I named above, they will know that I am or have been receiving mental health service.

Disclosure of information shall be limited to the following types of information (check one or more):

- Clinical Assessment                       Clinical Diagnosis                       Therapy Goals
- Treatment Plan                               Verbal Progress Report                       Therapy Notes
- Discharge Summary                       Psychological Evaluation                       Social History
- Other (specify): \_\_\_\_\_

The information to be released is for service provided during the period. (Specify exact or approximate date.)

From \_\_\_\_\_ to \_\_\_\_\_  
Date Date

I understand that I may withdraw this consent at any time except to the extent that the action has already been taken. If consent is not withdrawn, it shall end one year from the date of signature.

\_\_\_\_\_

\_\_\_\_\_  
Signature of person receiving services Date

\_\_\_\_\_  
Signature of parent/guardian/managing conservator, if applicable Date

\_\_\_\_\_  
Signature of witness if person is unable to sign Date

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**Policies and Procedures on Release of Information**

1. Our consent form to release Information/Records must be signed by all clients in person prior to any release of Information/Record. In a case where a client signed a Consent to Release Information/Record in another organization, he or she must still come to our office to sign our own copy of Consent Form to Release Information/Records before any release can take place.
2. For couple therapy, both couples must sign consent to release information.
3. Information/Records may not be released on cases that show an unpaid or outstanding balance until the balance is paid in full
4. A minimum of two weeks should be allowed for the release of regular records
5. Fees assessed for the preparation and release of documents are as follows:
  - i. \$60.00 for letter
  - ii. \$60.00 for Disability document
  - iii. \$100.00 for regular records
  - iv. \$200.00 for FMLA related document
  - v. \$300.00 for court related document

(Some agency sharing of records for service coordination may not attract these fees)

6. Please note that we do not physically represent clients in the Court. We may send records to Courts as needed.

Oasis Counseling and Educational Services reserves the right to adjust its fees in keeping with its clients’ needs. Special circumstances and request for fee adjustment should be brought to our Executive Director’s attention for discussion and possible action. Payment is due before or at the start of the time service is rendered. Special payment arrangements can be made; for example, it is possible to arrange for payment to be paid in advance over a period of time or in lump-sum.

\_\_\_\_\_  
Signature of person receiving services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian/Responsible Party

\_\_\_\_\_  
Date

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**Sessions Cancellation Policy**

It is important for clients to attend all their sessions except in a genuine emergency.

Cancelled/no-show sessions are counterproductive and increase the time it takes to overcome problems; and sometimes may make it impossible to achieve all goals. It is clients' responsibility to keep track of their appointments. Our voicemail is available after hours, 24 hours, seven days a week, with a confidential message center. Please give at least 24 hours' notice of cancellation.

We will bill you directly a fee of \$60.00 for the same day cancellation/no-show appointments.

Insurance and managed care companies do not pay for these sessions.

Clients with three consecutive cancellations are required to schedule a meeting with our director to reevaluate and make decision concerning future appointment scheduling. Exceptions are clients with emergency or health related cases; in such circumstances, we would need to be notified on timely manner.

**Please sign the following statement to indicate that you have read and understood this policy:**

*I have read and understood the policy concerning late cancelled/no-show sessions. I understand that I will be billed for all late cancelled/no-show sessions for which I have not given 24 hours' notice. I agreed to pay for these sessions.*

\_\_\_\_\_  
Signature of person receiving services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian/Responsible Party

\_\_\_\_\_  
Date



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**FMLA and Disability Forms Completion Policy**

We may complete FMLA and Disability forms for clients that have received services from us consistently for a minimum of 6 sessions. This is to help us determine if FMLA or Disability is for the best interest of our clients. Unfortunately, we do not complete these forms for clients that do not meet the above requirement.

Please sign the following statement to indicate that you have read and understood this policy:

*I have read and understood the policy concerning FMLA and Disability Forms Completion.*

\_\_\_\_\_  
Signature of person receiving services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian/Responsible Party

\_\_\_\_\_  
Date