

OASIS COUNSELING AND 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 Couples' Therapy:

Name (Partner # 1): _____ Date of birth _____

Social Security Number: _____ Phone #: _____

Home # _____ - _____ - _____ Work # _____ - _____ - _____ Cell # _____ - _____ - _____

Emergency Contact Name _____ Phone # _____ - _____ - _____

Individual's Address _____ City/State/Zip _____

Insurance Name: _____ Ins. ID #: _____ Ins. 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 #: _____ Authorization EXP Date _____ Name of EAP program _____

EAP Phone#: _____ Number of sessions authorized _____

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 _____

On a scale of 0 to 10 where 0 means "I do not want to work on this relationship" and 10 means, "I completely want to work on this relationship", how much do you want to work on this **relationship** _____

Are you happy in this relationship? Yes _____ No _____

If no, please provide an explanation:

If married, total number of marriages for you _____

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

Name	Age	Sex	Relationship to the individual	Live in the individual home?

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

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		_____

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? Yes _____ No _____

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 _____

When you have a problem, who is the person you can most rely on? _____

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

A.M. drinking

Hiding Supply

Prescription abuse

Blackouts

Pre-drinking

Sneaking use

Use to reward self

Unable to stop

Use to reduce stress

Tolerance

Guilt or remorse

Tremors

High Blood Pressure

Hepatitis

Seizures

Ulcers

Nosebleeds

Gastritis

Delirium

Other symptoms, elaborate (including trigger events) _____

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

Treatment History

Detoxification: _____ Outpatient: _____ After care: _____
 Other: _____ Inpatient: _____ Longest abstinence: _____

Counseling History

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

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)?

What are your therapy goals?

1. _____
2. _____
3. _____
4. _____

Do you have 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			

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

Name (Partner # 2): _____ **Date of Birth:** _____

Social Security Number: _____ **Phone #:** _____

Home # _____ - _____ - _____ **Work #** _____ - _____ - _____ **Cell #** _____ - _____ - _____

Emergency Contact Name _____ **Phone #** _____ - _____ - _____

Individual's Address _____ **City/State/Zip** _____

Insurance Name: _____ **Ins. ID #:** _____ **Ins. 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 #: _____ **Authorization EXP Date** _____ **Name of EAP program** _____

EAP Phone#: _____ **Number of sessions authorized** _____

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** _____

On a scale of 0 to 10 where 0 means "I do not want to work on this relationship" and 10 means, "I completely want to work on this relationship", how much do you want to work on this **relationship** _____

Are you happy in this relationship? _____ Yes _____ No _____

If no, please provide an explanation:

If married, total number of marriages for you _____

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

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

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

Distractibility	Loneliness	Withdrawing
Drug Dependence	Memory Impairment	Other _____
Eating Disorder	Mood Swings	_____
Eloping	Panic Attacks	_____

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? Yes _____ No _____

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

When you have a problem, who is the person you can most rely? _____

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 | A.M. drinking | Hiding Supply | Prescription abuse |
| Blackouts | Pre-drinking | Sneaking use | Use to reward self |
| Unable to stop | Use to reduce stress | Tolerance | Guilt or remorse |
| Tremors | High Blood Pressure | Hepatitis | Seizures |
| Ulcers | Nosebleeds | Gastritis | 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 with family

Current problem (s) or concern (s):

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

5. _____ How long? _____

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

6. _____ How long? _____
 7. _____ How long? _____
 8. _____ How long? _____

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

What are your therapy goals?

5. _____
 6. _____
 7. _____
 8. _____

Do you have 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's and couples' 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/couple is not predictable. Your therapist is available to support you throughout the counseling process.

Partner #1's Signature	Date
Partner #2's Signature	Date

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

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, Dr. 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. It is important for you to recognize that this is your therapy and Dr. Okafor would encourage you to be an active participant in it. If you have questions or concerns, please 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, Conflict resolution, Mediation, 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), grief, communication problems, attention deficit and hyperactivity (ADHD), 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 her family and friends, listening to music, dancing, and meditation.

Signature of Partner #1

Date

Signature of Partner #2

Date

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

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 Partner #1

Date

Signature of Partner #2

Date

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

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 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. There are fees for the preparation and release of documents. Please check with our staff during your first session for pricing. (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.
7. 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 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 Partner #1

Date

Signature of Partner #2

Date

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

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:

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

Signature of Partner #1

Date

Signature of Partner #2

Date

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

Consent for Treatment

We _____
(Couple's Names)

Hereby authorize: *Oasis Counseling and Educational Services*
(Individual/Agency/Organization)

Address: *8035 East R. L. Thornton FWY, Suite 334, Dallas, TX 75228*
(Street, City, State and ZIP Code)

To provide therapy to:

(Couple's Names)

Address: _____
(Street, City, State and ZIP Code):

We understand that we may withdraw this consent and stop the service at any time.

Signature of Partner #1

Date

Signature of Partner #2

Date

OASIS COUNSELING AND EDUCATIONAL SERVICES

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

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:

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

Signature of Partner #1

Date

Signature of Partner #2

Date