Rapha Counseling, LLC.
1111 NE 25th Ave.
Bldg. 400 Suite 402
Ocala, Florida 34470

Client Information & Case History

Date:_____ Client's #_____ Therapist:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D Religious Status: _____

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____ May we contact you by e-mail if necessary? _____

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment:_____

_____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

_____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety
__ Depression
__ Anger
__ Abandonment t
__ Alcoholism
__ Drug Addiction
__ Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: _____

Rapha Counseling, LLC.
1111 NE 25th Ave.
Bldg. 400 Suite 402
Ocala, Florida 34470

Client's Name: _____ Date: _____

What medications or drugs are you taking? (List name and dosage)

_____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____
_____
_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?_____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
Do you sleep well at night? _____ If no, why not? _____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY:
Parents:
Father: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Mother: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____
_____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__ Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

Please check any and all insurance coverage that may be applicable in this case**:**
___ Major Medical ___ Medical Savings Account or Flex Plan _____
___ Other _____
Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

Rapha Counseling, LLC.
1111 NE 25th Ave.
Bldg. 400 Suite 402
Ocala, Florida 34470

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Case History

Name _____ Date _____

1. What is your major concern? _____

   _____

   _____

   _____

   Other concerns: _____

   _____

   _____

2. If this is a recurrence, when was the first time you noticed this problem?_____

   How did it originally occur?_____

   _____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? _____

   _____

3. How frequent is the condition? Constant _____ Intermittent ____

   What causes the problem to come on/get worse?

   _____

   _____

   _____

Rapha Counseling, LLC.
1111 NE 25th Ave.
Bldg. 400 Suite 402
Ocala, Florida 34470

4. Are there any other conditions you would like to discuss?

Yes _____ No _____. If yes, describe: (continue on next page)

_____

_____

Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

_____

5. Is there anything you can do to relieve your major problem? Yes ___ No ___. If yes, describe:

_____

If no, what have you tried to do that has not helped? _____

_____

6. What makes the problem worse? _____

_____

9.. Remarks: _____

_____

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

Please place an "X" on the line above to indicate level of problem.

Therapist's Signature _____ Date _____