Today's Date _____

FULLER LIFE FAMILY THERAPY LOCATED AT: **4545 BISSONNET, SUITE 289 BELLAIRE, TEXAS 77401**

- ☐ Angela E. Blocker, LMFT-Associate
- ☐ Manet Castañeda, LPC Intern
- ☐ Tamara Tatum, LMFT-Associate
- ☐ Shani Bell, MAAT, LPC Intern
- ☐ Dormetra Henry, Practicum Student Therapist
- ☒ Supervised by Amy Fuller, PhD, LMFT-S, LPC-S

Please complete the following 5 pages as completely as possible. Please print or write legibly.

Each person attending therapy needs to complete pages 2 & 3 and sign pages 4 & 5.

Client Information

Client Name: First Middle Last

Address: Street/Apt #) City State Zip

( )_____( )_____ ( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____

Date of Birth Age Driver's License Number

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email Address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

Spouse or Guardian Information

Name: First Middle Last

Address: Street State Zip

( )_____( )_____ ( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____

Date of Birth Age Driver's License Number

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email Address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

If client is under 18, Information on Father

Father's Name: First Middle Last

Address: Street State Zip

( )_____( )_____ ( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____

Date of Birth Age Driver's License Number

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

If client is under 18, Information on Mother

Mother's Name: First Middle Last

Address: Street State Zip

( )_____( )_____ ( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____

Date of Birth Age Driver's License Number

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

Please list additional family members living in the home of the client:

Name: First Last Date of Birth Age Relationship to client

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Name: First Last Date of Birth Age Relationship to client

Name: First Last Date of Birth Age Relationship to client

Each person attending therapy needs to complete pages 2 & 3 and sign pages 4 & 5. ***NAME:*** _____

What are your reasons for being here? _____

_____

_____

How did you hear about this professional? ☐ Friend ☐ Family Member ☐ Former Client ☐ Physician ☐ Shepherd's Guide ☐ Phonebook
☐ Other Professional ☐ Pastor ☐ Website: (website name:_____)
☐ Other: _____ Please list name or more information:_____

Medical and Emergency Information

_____ _____ _____
Name of Primary Physician | Doctor's Phone Number | Date of last Visit

_____ _____ _____
Contact in Case of Emergency: Name Address | Phone Numbers | Relationship to client

Please list all current medications:

Name of Medication	Dosage	Times per day (am/pm)	Prescribing Physician	Type of medication

Current Client Symptoms: Please rate all that apply from 1 to 3 (1-Low, 2-Moderate, 3-High Concern)

☐ Family problems	☐ Feel sad or depressed	☐ Anxiety/worry	☐ Hear strange things
☐ Marital/relationship	☐ Cry often	☐ Stress	☐ See strange things
☐ Trouble communicating	☐ Feel hopeless	☐ Extreme fear	☐ Wanting to hurt others
☐ Physical or sexual abuse	☐ Anger problems	☐ Panic attacks	☐ Suicidal thoughts
☐ Domestic violence	☐ Frustration	☐ Aggressive behaviors	☐ Others are out to get me
☐ Sexual problems	☐ Trouble concentrating	☐ Nightmares	☐ Thoughts of Death
☐ Intimacy issues	☐ Trouble sleeping	☐ Upset stomach	☐ Wanting to hurt myself
☐ Divorce	☐ Feel guilty	☐ Health Problems	☐ Legal problems
☐ Pre-marital counseling	☐ Low self-esteem	☐ Severe pain	☐ Financial problems
☐ Grieving	☐ Loss of appetite	☐ Headaches	☐ Smoke cigarettes
☐ Lack of sex drive	☐ Dramatic weight changes	☐ Sweating	☐ Alcohol use
☐ Spiritual Issues	☐ Feel tired or low energy	☐ Trouble breathing	☐ Drug use
☐ Can't make friends	☐ Lack of motivation	☐ Quick mood changes	☐ Restless/Can't sit still
☐ Feel Lonely	☐ Problems at work	☐ Can't stop thinking	☐ Impulsive
☐ Withdrawn from others	☐ Problems at school	☐ Eating Disorder	☐ Other:_____

Please explain: _____

_____.

Spirituality (optional)

_____ Please describe your involvement: ☐ Active ☐ Somewhat Active ☐ Inactive
Spirituality/Religious Affiliation If Active or Inactive, How long? _____
What are your spiritual and/or religious beliefs?

_____

Would you like this to be a part of your therapy? ☐ Yes ☐ No ☐ Unsure

Each person attending therapy needs to complete pages 2 & 3 and sign pages 4 & 5. ***NAME:*** _____

Client History (Circle YES or NO. If YES, please Explain)			
Any **previous counseling**? If so, with whom? When and for how long?	NO	YES	
Any major illnesses or serious **medical problems**?	NO	YES	
Any **Previous hospitalizations**?	NO	YES	
Does client have **addictions**? (Drug, alcohol, pornography, gambling, computer, etc).	NO	YES	
Does client **smoke**? If so, how much per day?	NO	YES	
Does client drink **alcoholic** beverages? If so, how much per day?	NO	YES	
Has client had recent **changes in weight** or eating habits? Any history of **eating disorders?** (anorexia, bulimia, overeating, emotional eating)	NO	YES	
Has client been in **trouble with the law**?	NO	YES	
Has client had a history of employment changes or **difficulty at work?**	NO	YES	
Has client had **trouble with school**? (truant, etc.)	NO	YES	
Has client exhibited **physical aggression or threats** of harm toward others?	NO	YES	
Has client exhibited **cruelty to animals**?	NO	YES	
Has client shown **destructive tendencies toward property?** (setting fires, vandalism or destruction of property)	NO	YES	
Does client have **military history**? (If yes, list military history and discharge type. Any field duty conducive to trauma or post traumatic stress?)	NO	YES	
List all **major traumas.** (loss of child or loved one, robbery, feared death experiences)	NO	YES	
Does client have a history of **sexual, physical or emotional abuse?**	NO	YES	
Has client exhibited **inappropriate sexual behaviors**?	NO	YES	
Did client experience any known **developmental problems** in infancy, childhood, or adolescence? (hearing, speech, walking, surgery, premature birth, learning disabilities, etc.)	NO	YES	
Has client had any **legal issues**, past and or present?	NO	YES	
Any other situation, experience or concerns which therapist should be aware?	NO	YES	

Client Informed Consent to Treatment

Information for New Clients
I acknowledge I have access to the document with important information for new clients called Information for New Clients. I acknowledge my awareness regarding Fuller Life's policies regarding social media and communication. These documents are available at www.FullerLifeFamilyTherapy.org/forms, in our waiting room and from your therapist.

Receipt of HIPAA Notice of Privacy Practices
I acknowledge notice of availability of Notice of Privacy Practices (see info for new clients). I understand a copy of this document can be provided at my request. I certify that have read the Federal HIPAA Ruling provided by this office.

Video Recording for Supervision Purposes
I acknowledge that I have received notification that video equipment will be used during sessions for supervision purposes. Cases are respectfully discussed in a confidential situation when appropriate. The digital recording will be destroyed within a month of taping. I understand Fuller Life is a training institute and consent to treatment.

_____ _____ _____ _____
Client Signature **Date** **Parent/Guardian or Spouse Signature** **Date**

Financial Agreement

I understand that the agreed upon contracted rate for per session will be $_____.

_____ _____ _____
Responsible Party for Payment | Relationship to Client | Phone

_____ _____ _____ _____ _____
Address: (if different from client) | City | State | Zip | Additional Phone

By seeking services, I agree to pay all fees for counseling and other services. I have received and read the document providing Information for New Clients and am fully responsible for payment of services.

- I understand that I will be charged the **full** contracted rate for each session not cancelled 24 hours in advance.
- I understand individual sessions last 45-50 minutes and family/marital sessions last 50-55 or minutes. An additional fee applies when sessions exceed this time.
- I understand that I am responsible for all payments. I certify that all the information on this form is true. If client is under 18, I consent to the client's participation in counseling and accept responsibility for payment.

Please provide a credit card to cover therapy services. A credit or debit card number is required by Fuller Life policy, however, payments may be made by cash or check. Payments are due in full at the time services are rendered.

Select your preferences for method of payment: ☐ Cash ☐ Check ($35 returned check fee) ☐ Credit Card on file (below)

_____ _____ ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex CVC/CVV: _____
Credit Card Number | Expiration Date | (3 digit code on back)

_____ _____ _____ _____ _____
Credit Card Address (if different from client) | City | State | Zip | Phone Number

_____ _____ _____ _____
Client Signature **Date** **Parent/Guardian or Spouse Signature** **Date**

This signature acknowledges understanding of the above financial statement and authorizes Fuller Life Family Therapy to charge the card for late cancellations or no-shows.

Communication Preferences Form

FULLER LIFE
Family Therapy Institute

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

Name of Client	Name of Spouse/Guardian/Parent
Primary Email	Primary Email (Spouse/Guardian)
Primary Phone	Primary Phone (Spouse/Guardian)

It may become useful to communicate by email, text message, or other electronic methods of communication which are NOT typically a confidential means of communication. There is a reasonable chance that a third party may be able to intercept and eavesdrop on these electronic messages.

For this reason, Fuller Life Therapists use only HIPAA Compliant Secure forms of communication **UNLESS** you indicate a desire to communicate in non-secure means. We offer encrypted email and a secure texting platform to ensure HIPAA-Compliance and the highest standard of electronic confidentiality. (*See Info for New Clients*)

EMAIL:

Client Preference: ❍ unsecured / unencrypted email ❍ unsecured "normal" email ❍ unsecure except financial or clinical
Spouse/Guardian: ❍ unsecured / unencrypted email ❍ unsecured "normal" email ❍ unsecure except financial or clinical

TEXT MESSAGES: Fuller Life Therapists use 8X8, HIPAA-Complaint service, for secure text and only scheduling related texts.

Client Preference: ❍ Text messages for scheduling only ❍ No text messages for scheduling only
Spouse/Guardian: ❍ Text messages for scheduling only ❍ No text messages for scheduling only

RESOURCES (OPTIONAL): Dr. Fuller and Fuller Life Family Therapy share resources and articles related to mental, relational, emotional and spiritual well-being on a monthly newsletter.

Client Preference: ❍ Yes I would like to receive email with resources ❍ Not at this time
Spouse/Guardian: ❍ Yes I would like to receive email with resources ❍ Not at this time

EMAIL APPOINTMENT REMINDERS: Appointment Reminders are a courtesy offered by email approximately 36 hours prior to the appointment. *Only one email address can receive the reminders.* ***(NOTE: These are NOT encrypted emails and will come from donotreply@psyquel.com).**

Select one please: ❍ reminder to client email ❍ reminder to spouse/guardian email ❍ no email reminder please

SOCIAL MEDIA:
Our group at Fuller Life Family Therapy is active on various social media platforms providing professional resources for mental and relational health. You are welcome to follow us on our professional blog, Twitter, Facebook, Connect on Linked In or Scoop It. If you choose to do so please know this may compromise your confidentiality at your own choice. Do not send any direct communication through these professional social media accounts. (*See Information for new clients.)*

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.
I understand I can find out more about Fuller Life Communication Policies and Social Media Policies in the Information for New Clients Document and I will comply with the guidelines provided in these policies.

Signature of client	Date	Signature of Spouse/Guardian	Date

Signature of Therapist: _____ Date: _____

Each person attending therapy needs to complete pages 2 & 3 and sign pages 4 & 5. NAME: _____

What are your reasons for being here? _____

_____

_____

How did you hear about this professional? ☐ Friend ☐ Family Member ☐ Former Client ☐ Physician ☐ Shepherd's Guide ☐ Phonebook
☐ Other Professional ☐ Pastor ☐ Website: (website name:_____)
☐ Other: _____ Please list name or more information:_____

Medical and Emergency Information

Name of Primary Physician	Doctor's Phone Number	Date of last Visit

Contact in Case of Emergency: Name	Address	Phone Numbers	Relationship to client

Please list all current medications:

Name of Medication	Dosage	Times per day (am/pm)	Prescribing Physician	Type of medication

Current Client Symptoms: Please rate all that apply from 1 to 3 (1-Low, 2-Moderate, 3-High Concern)

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☐ Feel Lonely	☐ Problems at work	☐ Can't stop thinking	☐ Impulsive
☐ Withdrawn from others	☐ Problems at school	☐ Eating Disorder	☐ Other:_____

Please explain any of the above symptoms: _____

_____.

Spirituality (optional)

_____ Please describe your involvement: ☐ Active ☐ Somewhat Active ☐ Inactive
Spirituality/Religious Affiliation If Active or Inactive, How long? _____
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Has client had any **legal issues**, past and or present?	NO	YES	
Any other situation, experience or concerns which therapist should be aware?	NO	YES	