FULLER LIFE
Family Therapy Institute

Confidential Initial Session Form

Each person attending therapy will need to complete this form. Today's Date:
If attending with a minor, please complete for each minor.

Full Name: Nickname: Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Street Address:

City: State: Zip:

Primary Phone:
Type of phone: ☐ *Mobile* ☐ *Home* ☐ *Work* ☐ *Other*
Is it ok to leave a message at this number? ☐ *Yes* ☐ *No*
Are scheduling related text messages ok? ☐ *Yes* ☐ *No*

Secondary Phone:
Type of phone: ☐ *Mobile* ☐ *Home* ☐ *Work* ☐ *Other*
Is it ok to leave a message at this number? ☐ *Yes* ☐ *No*
Are scheduling related text messages ok? ☐ *Yes* ☐ *No*

Email:
Email is not always secure; Choose your preference: ☐ *Normal Email* ☐ *Encrypted Email* ☐ *No Email Please*
Would you like to receive resources from Fuller Life related to mental, relational, or emotional wellbeing? ☐ *Yes* ☐ *No*
Our offices send out appointment reminders approximately 36 hours prior to each scheduled session. This reminder can be delivered to only one email address. Do you want a reminder at the above email address? ☐ *Yes* ☐ *No*
Please send reminder to this email address:

Type of therapy in which you will participate:
☐ Individual therapy ☐ Couples therapy
☐ Family therapy ☐ Therapy for child
☐ Therapy for adolescent ☐ Unsure
☐ Other:

Names and ages of all who live in the home:

Age:
Date of Birth:
Gender:
☐ Male
☐ Female
☐ Trans
Sexual Orientation:
☐ Heterosexual
☐ Homosexual
☐ Bisexual
☐ Unknown or N/A
☐ Other:

Marital Status:
☐ Cohabitating
☐ Divorced
☐ Married
☐ Separated
☐ Single
☐ Widowed
☐ Other:
If married or cohabitating:
Name of Partner:
Anniversary Date:

Ethnicity:
☐ African American
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Middle Eastern
☐ Mixed Race
☐ Other:

Religion/Spirituality:
☐ Catholic ☐ Christian
☐ Judaism ☐ Islam
☐ Buddhism ☐ Hinduism
☐ Atheist/Agnostic
☐ Native American
☐ Unknown or N/A
☐ Other
In above religion, are you
☐ *Active* ☐ *Somewhat Active*
☐ *Inactive* ☐ *N/A*
Would you like spirituality to be a part of therapy? ☐ *Yes* ☐ *No* ☐ *Unsure*

Highest level of education:
☐ Preschool ☐ Elementary ☐ Middle School ☐ High School
☐ High School Graduate ☐ Some College ☐ Associates Degree
☐ Para-professional Degree ☐ College Graduate
☐ Master's Degree ☐ Professional degree or PhD
☐ Other:

Employer:

Occupation or Job Title:

How did you hear about Fuller Life?
☐ *AAMFT* ☐ *Amy Fuller website* ☐ *Facebook* ☐ *Family member* ☐ *Former Client* ☐ *Friend* ☐ *Fuller life website* ☐ *Google Ad* ☐ *Google Search* ☐ *Houston Marriage counselor website* ☐ *Other professional* ☐ *Pastor* ☐ *Physician* ☐ *Psychology Today* ☐ *Scoopit* ☐ *Twitter* ☐ *Website* ☐ *Yelp* ☐ *Other:*
If friend or Professional referral, Name:

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NAME:

Each person attending therapy will need to complete this form. If attending with a minor, please complete for each minor.

What are your reasons for seeking therapy?

Have you been in counseling before? ☐ *Yes* ☐ *No*
(If yes, please describe type of therapy, dates, length of treatment and name of professional.)

Please check any concerns you have:

☐ Aggressive Behaviors	☐ Infidelity	☐ Quick mood changes
☐ Alcohol or drug use	☐ Insomnia	☐ Pre-marital Counseling
☐ Anger, Stress, or Anxiety	☐ Intimacy Issues	☐ Problems at work
☐ Depression	☐ Legal problems	☐ Problems at school
☐ Divorce or separation	☐ Marital Problems	☐ Sexual Abuse
☐ Domestic Violence	☐ Mental Health Concern	☐ Sexual Problems
☐ Family Problems	☐ Pain Management	☐ Social difficulty
☐ Financial Problems	☐ Parenting concerns	☐ Suicidal thoughts
☐ Grief, Loss or Trauma	☐ Physical Abuse	☐ Trouble with eating or weight
☐ Health Problems	☐ Sexual Abuse	☐ Other:
Comments:		

Please check any symptoms you are having:

☐ Communication	☐ Feel Lonely	☐ Aggressive Behaviors	☐ Hear Strange Things
☐ Lack of Sex Drive	☐ Withdrawn from Others	☐ Lying or Dishonesty	☐ See Strange Things
☐ Anger Problems	☐ Feeling Sad or Down	☐ Nightmares	☐ Thoughts of Death
☐ Frustration	☐ Trouble Concentrating	☐ Upset Stomach	☐ Others Out to Get Me
☐ Trouble Sleeping	☐ Cry Often	☐ Severe Pain	☐ Wanting to Hurt Others
☐ Feel Guilty	☐ Feel Hopeless	☐ Headaches	☐ Wanting to Hurt Myself
☐ Problems at Work	☐ Low Self-Esteem	☐ Sweating	☐ Suicidal Thoughts
☐ Problems at School	☐ Loss of Appetite	☐ Trouble Breathing	☐ Smoke Cigarettes
☐ Excessive Worry	☐ Weight Changes	☐ Can't Stop Thinking	☐ Alcohol Use or Abuse
☐ Stress	☐ Feeling Tired	☐ Disordered Eating	☐ Drug Use or Abuse
☐ Extreme Fear	☐ Low Energy	☐ Binging	☐ Other:
☐ Panic Attacks	☐ Low Motivation	☐ Restless/Can't Sit Still	
☐ Spiritual Issues	☐ Quick Mood Changes	☐ Impulsive	
Please list any additional current symptoms or concerns or comment about the above concerns:			

History: Please check of any of the following that are a part of your history or present concern:

☐ addictions	☐ military history	☐ trouble with law
☐ alcohol use or abuse	☐ physical aggression	☐ trouble with school
☐ cruelty to animals	☐ previous hospitalizations	☐ violence to property
☐ medical problems	☐ smoking	☐ weight changes
	☐ trauma	
Comments:		

Medical:

Primary Physician Name:		Phone for Physician:	
Name of current medications:	Dosage:	Reason for medication	Prescribing physician

Emergency Contact Name:	Emergency Contact Phone	Relationship to Emergency Contact

Please provide any additional information you feel would be helpful:

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life: Name: _____

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

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Consent to Treatment

Please check each box and sign. Each person participating over the age of 18 needs to complete and sign.

Name: **If for a minor, minor's Name:** **Minor's Age:**

Information for New Clients

☐ I acknowledge I have access to the document with important information for new clients called Information for New Clients. documents are available at www.FullerLifeFamilyTherapy.org/forms, in our waiting room and from your therapist.

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 or have access to read the Federal HIPAA Ruling provided by this office.

Communications Preferences

Clients have the rights to indicate methods of preferred communication. Our initial session client information form asks each person to select preferences for communication in regard to email, phone or text messages. 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 offers encrypted email and a secure texting platform to ensure HIPAA-Compliance and the highest standard of electronic confidentiality. If you wish to change your email preference with our offices at any time, please speak to your therapist. If you authorized appointment reminders, please know these messages will not be secure or encrypted.

☐ 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.

Video Recording for Supervision Purposes

☐ I acknowledge that I have received notification that video equipment will be used during sessions for supervision and training 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.

Social Media Policies

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.

☐ 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.

☐ I certify I am over the age of 18 and able to consent to treatment for myself or the client listed below. 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.

Signature:	Date:

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Financial Agreement

To be completed about the party responsible for payment and signed by all participating adults.

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

Name of Responsible Party:

Relationship to Client: Self Partner Parent Other: Email:

Phone:

Address: City: State: Zip:

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.

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

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.

Card Type: Visa MasterCard Discover Amex

Credit Card Number:

Expiration Date:

CVC: (3 digit code):

Billing Zip code:

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

Signature: Date:

Insurance Coverage: If you are seeing an LPC or LMFT, our office will verify your insurance benefits and submit the claim on your behalf. If you would like us to verify benefits please provide the following:

Name of Insured:
DOB of Insured:
SS# of Insured:
Ins. Zip Code:

Insurance Company Name:
Insurance Policy Number:
Insurance Group Number
Insurance Company Phone: