THERAPY OFFICE LOCATED AT:	4545 BISSONNET, SUITE 289 BELLAIRE, TEXAS 77401

Amy M Fuller, PHD, LPC, LMFT Today's Date: ________________

CONFIDENTIAL CLIENT INFORMATION

Please complete the following 4 pages as completely as possible. Please print or write legibly.

****Each person is asked to complete pages 3 and 4.**

Client Information

____
Client Name: First Middle Last

____
Address: Street/Apt #) State Zip
Please CIRCLE primary phone for appointment reminders.

( )______________( )______________( )______________
Phone: Home Cell Work
It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

☐ Yes, I want to receive email from Dr. Amy Fuller ______/______/______ Date of Birth ______ Age

______________ 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
Please CIRCLE primary phone for appointment reminders.

( )______________( )______________( )______________
Phone: Home Cell Work
It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

☐ Yes, I want to receive email from Dr. Amy Fuller ______/______/______ Date of Birth ______ Age

______________ 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
Please CIRCLE primary phone to be used for appointment reminders.

( )______________( )______________( )______________
Phone: Home Cell Work
It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

☐ Yes, I want to receive email from Dr. Amy Fuller ______/______/______ Date of Birth ______ Age

______________ 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
Please CIRCLE primary phone to be used for appointment reminders.

( )______________( )______________( )______________
Phone: Home Cell Work
It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

☐ Yes, I want to receive email from Dr. Amy Fuller ______/______/______ Date of Birth ______ Age

______________ 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 (or age)	Relationship to client

Billing Information

Responsible Party for Payment ______ Relationship to Client ______ Phone ______

Address ______ City ______ State ______ Zip ______ Additional Phone ______

Please indicate method of payment for therapy services:
Payments are due in full at the time services are rendered. Payments will be made with ☐ Cash ☐ Check ($35 returned check fee) ☐ Credit Card on file

Please check the following regarding insurance.
☐ I do not have/or plan to use my health insurance.
☐ Please bill insurance for me. (Insurance will reimburse client)
☐ I will bill my own insurance using the receipt provided.

Insurance Information

Primary Insurance Name ______ Insurance Phone Number ______

Insurance Billing Address ______ City, State, Zip ______

Member ID # ______ Policy Number ______

Name of Insured ______ Social Security # of Insured ______

Address of Insured (if different from above) ______ City, State, Zip ______

Insured Employer: ______ Work Phone # of Insured ______

☐ Male ☐ Female ______ ______
Gender of Insured ______ Date of Birth ______

Secondary Insurance Name ______ Insurance Phone Number ______

Insurance Billing Address ______ City, State, Zip ______

Member ID # ______ Policy Number ______

Name of Insured ______ Social Security # of Insured ______

Address of Insured (if different from above) ______ City, State, Zip ______

Insured Employer: ______ Work Phone # of Insured ______

☐ Male ☐ Female ______ ______
Gender of Insured ______ Date of Birth ______

Financial Agreement (Please check each box to indicate agreement)

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 a $85 fee for the first session not cancelled 24 hours in advance, and the full fee of $185 for all future no-shows or sessions not canceled 24 hours in advance.
- ❖ I understand individual sessions last 50 minutes and family/marital sessions last 60 minutes for $185 due at the end of the session. Initial couples/family therapy sessions are 90 minutes at $275. I have received and read the document with information for new clients. I understand that I am responsible for all payments.
- ❖ If I request this office to file insurance claims, I hereby authorize this professional, staff, or designated billing entities to release any necessary information to my insurance carrier to process claims. I certify that all the information on this form is true. If client is under 18, I consent to the client's participation and accept responsibility for payment.

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

Receipt of HIPPA 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 HIPPA Ruling provided by this office.

______ ______
Client Name or Signature **Date**

CREDIT CARD (OPTIONAL)

☐ **Charge my credit card for payments on account or to pay for sessions of dependent, spouse or other.**

Credit Card Number ______ Expiration Date ______ ☐ Visa ☐ MasterCard ☐ Discover ☐ *CVC Code: ______

Credit Card Address ______ City ______ State ______ Zip ______ Phone Number ______

Signature ______ Date ______

**Please have each person present at the first session complete pages 3 and 4. *NAME:____________________

FULLER LIFE FAMILY THERAPY LOCATED AT: *4545 BISSONNET, SUITE 289, BELLAIRE, TEXAS 77401*	**CONFIDENTIAL CLIENT INFORMATION, PAGE 3 of 4**

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 issues	☐	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 any of the above symptoms: ____

____

____
.

Religion (This section is optional)

______________________________ Please describe your involvement: ☐ Active ☐ Somewhat Active ☐ Inactive
Religious Affiliation If Active or Inactive, How long? ______________________________

What are your religious beliefs? ____

****Each person present at the first session is asked to complete this page.** ***NAME:____________________**

Client History	**(Circle YES or NO. If YES, please Explain Below)**		
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	