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 5 pages as completely as possible. Please print or write legibly.

****Each person is asked to complete pages 2 and 3 and sign pages 4 and 5.**

Client Information

____
Client Name: First Middle Last

____
Address: Street/Apt #) State Zip

Please complete the communications preferences form on page 5.

( )______________( )______________( )______________
Phone: Home Cell Work

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

_______/_______/_______ ________ _______/_______/_______
Date of Birth Age Anniversary Date (if applicable)

____________________ ____________________
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 complete the communications preferences form on page 5.

( )______________( )______________( )______________
Phone: Home Cell Work

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

_______/_______/_______ ________ _______/_______/_______
Date of Birth Age Anniversary Date (if applicable)

____________________ ____________________
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

_______/_______/_______ ________ _______/_______/_______
Date of Birth Age Anniversary Date (if applicable)

____________________ ____________________
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

_______/_______/_______ ________ _______/_______/_______
Date of Birth Age Anniversary Date (if applicable)

____________________ ____________________
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
Name: First	Last	Date of Birth	Age	Relationship to client
Name: First	Last	Date of Birth	Age	Relationship to client
Name: First	Last	Date of Birth	Age	Relationship to client

**Please have each person present at the first session complete pages 2 and 3. *NAME:____________________

AMY FULLER PHD LOCATED AT:
4545 BISSONNET, SUITE 289, BELLAIRE, TEXAS 77401

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 spiritual beliefs? ____

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

***NAME:**___________________

Client History	NO	YES	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	

Billing Information

Responsible Party for Payment ____________ Relationship to Client ____________ Phone ____________

☐ Address is the same as client. ____________
Responsible Party Address ____________ City ____________ State ____________ Zip ____________

Please indicate preferences for therapy services:
Payments are due in full at the time services are rendered. Dr. Fuller's office will verify health insurance benefits and send off the claim as a courtesy to the patient. The insurance company would potentially reimburse the patient directly at a later date. Please discuss your insurance coverage options with our staff if you have questions.

☐ I do not have/or plan to use my health insurance.
☐ I am unsure of my benefits and would potentially like to use benefits if they cover therapy services.
☐ Please bill insurance for me. (Insurance will reimburse client. Dr. Fuller cannot guarantee reimbursement)
☐ I will bill my own insurance.

Primary Insurance Name	Insurance Phone Number	Secondary Insurance Name	Insurance Phone Number
Insurance Billing Address	City, State, Zip	Insurance Billing Address	City, State, Zip
Member ID #	Policy Number	Member ID #	Policy Number
Name of Insured	Social Security # of Insured	Name of Insured	Social Security # of Insured
Address of Insured (if different from above)	City, State, Zip	Address of Insured (if different from above)	City, State, Zip
Insured Employer:	Work Phone # of Insured	Insured Employer:	Work Phone # of Insured
☐ Male ☐ Female Gender of Insured	Date of Birth	☐ Male ☐ Female Gender of Insured	Date of Birth

Financial Agreement and Consent to Treatment (please check each box)

☐ **By seeking services, I agree to pay all fees for therapy 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 in full for any session not cancelled 24 hours in advance or no-shows.
I understand sessions last 50 minutes for $195 due at the end of the session. Initial couples or family therapy sessions are 80 minutes at $295. I understand that I am responsible for all payments regardless of their outcome.

☐ **I have received the document with Information for New Clients as well as the HIPAA Notice of Privacy Practices detailing how my private health information may be used.** 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** ____________

CREDIT CARD (REQUIRED)

A credit or debit card number is required and billed at the conclusion of the session, however, payments may be made by cash or check by speaking with our staff. This card will be charged for late cancellations or no-shows.

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

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

Signature ____________ **Date** ____________

Communication Preferences Form

Amy Fuller PhD
Help for today, Hope for Tomorrow

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

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

It may become useful during the course of treatment to communicate by email, text message or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Dr. Fuller there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. For this reason, Dr. Fuller uses only HIPPA Compliant Secure forms of communication UNLESS you indicate a desire to communicate in non-secure means. Dr. Fuller offers encrypted email and a secure texting platform to ensure HIPPA-Compliance. *(See Info for New Clients and Communication Policies for more info.)*

Client Email Preference:	Normal Unencrypted Email	Encrypted Secure Email	No Email
Spouse/Guardian Preference:	Normal Unencrypted Email	Encrypted Secure Email	No Email

TEXT MESSAGES:
Dr. Fuller uses a HIPPA-Complaint service to send secure text messages related ONLY to scheduling.

Client Preference: Text for schedule only No Text *Spouse Preference:* Text for schedule only No Text

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. Check the circle if you would like to receive these resources by email:
Client: Yes I want resources No thank you. *Spouse/Guardian:* Yes, I want resources No thank you.

APPOINTMENT REMINDERS:
Appointment Reminders are a courtesy offered by phone call and email approximately 36 hours prior to the appointment. Only one phone number and email address can receive the reminders. (these are NOT encrypted emails)

Email reminders to above client email Email reminders to above spouse/guardian email No email reminders

PHONE REMINDERS: Select only one please

Phone reminders to above client phone Phone reminders to above spouse/guardian No phone reminders

SOCIAL MEDIA:
Dr. Fuller is active on various social media platforms providing professional resources for mental and relational health. You are welcome to follow Dr. Fuller on her blog, the Fuller Life 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. Please do not send any direct communication through these professional social media accounts since they are not confidential. Furthermore, in order to ensure your confidentiality, please know that Dr. Fuller will not directly request to connect with you on these platforms. (See Information for new clients Social Media Policies for more info.)

PHYSIOLOGICAL MONITORING and RECORDING:
Dr. Fuller regularly consults with other experts in the field to improve the quality of her clinical skills. Dr. Fuller uses both physiological monitoring and video recording for consultation or training to ensure quality care or enhance the training of therapists with Fuller Life Family Therapy Institute, a post-graduate training site for master's level counselors and therapists. All recordings and information are used solely for the purpose of training and improved clinical care. Signature below grants permission to record therapy sessions and use physiological monitoring for training and research purposes and enhanced clinical care. If you have questions or concerns, please discuss them with Dr. Fuller or her assistant.

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 Dr. Fuller's 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

**Please have each person present at the first session complete pages 2 and 3. *NAME:____________________

AMY FULLER PHD LOCATED AT:
4545 BISSONNET, SUITE 289, BELLAIRE, TEXAS 77401

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	NO	YES	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	