

Amy M Fuller, PHD, LMFT, LPC

Today's Date: _____

CONFIDENTIAL CLIENT INFORMATION

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

Client Information

Client Name: First _____ Middle _____ Last _____

Address: Street/Apt #) _____ 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 (or age) _____	Relationship to client _____
Name: First _____	Last _____	Date of Birth (or age) _____	Relationship to client _____
Name: First _____	Last _____	Date of Birth (or age) _____	Relationship to client _____
Name: First _____	Last _____	Date of Birth (or age) _____	Relationship to 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:

- Self-Pay--I will pay at the time of service (Discount after the 1st session)
 - Bill Insurance—I will pay my co-pay. Please file insurance for me (no discount).
 - I will bill my own insurance & pay at the time of service (See New Client info for additional information)
- Payments and Co-Payments will be made by: Cash Check (\$35 returned check fee) Credit Card

Insurance Information

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 _____
<input type="checkbox"/> Male <input type="checkbox"/> Female _____	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female _____	Date of Birth _____
Gender of Insured _____	Date of Birth _____	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 \$50 fee for the first session not cancelled 24 hours in advance, a \$100 fee for the second session not cancelled 24 hours in advance, and the full fee for all other sessions.
- ❖ I understand individual sessions last 45-50 minutes and family/marital sessions last 60 minutes. An additional fee applies when sessions exceed this time. I have received and read document with information for new clients.
- ❖ 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 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.

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 (displayed on wall in reception area). 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 Other: _____

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

Signature _____ Date _____

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)

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

Please explain any of the above symptoms: _____

Religion (This section is optional)

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

What are your religious beliefs? _____

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	