Focus for Living, PLLC
308 East Renfro,
Suite 202
Burleson, Texas 76028
817-295-870

Office Use Only		
ID#	Intake Date:	Therapist:
Paid: Y/ N	Previous Client: Y/ N	Previous Date of FFL Service:
PW Signed □	Copy of DL □	Managing Conservator? Y N
Sole Custody	Joint Custody	Copy of Court Order (Bear Court's Signature)

Adolescent Intake Information

Welcome to *Focus for Living,* PLLC. In order to serve you better, we request that you take a few moments to fill out the following information as completely as you can.

GENERAL INFORMATION

Client's Full Name ____

Parents/ Guardians' Name(s) ____

Date of Birth ______________________________ Age _____ Male □ Female □

Address ____

City ____ State ________ Zip ___________

Cell Phone /Other ___________________________ Work Phone _______________________

Parents/ Guardians' Email Address: ____

May we call you at your **home**? □ Yes □ No Leave message? □ Yes □ No

May we call you at your **cell/office**? □ Yes □ No Leave message? □ Yes □ No

May we give you a **reminder call**? □ Yes □ No May we **text** your cell? □ Yes □ No

May we **email** you? □ Yes □ No May we **write** you at your home? □ Yes □ No

Race ___________________________ Handedness: Right / Left / Ambidextrous

Preferred Spoken Language: ________________ First Language Spoken: _____________

Who should we contact in case of emergency?

Name: __________________________ Relationship: __________________________

Address: ____

Home Phone: ______________________ Work/Cell Phone: _________________________

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[Rev 4/11/14]

ADOLESCENT PSYCHOSOCIAL HISTORY

FAMILY HISTORY

Date: ___________________

Client's Full Name: __________________________________ DOB: ________________ Age: ____
Mother's Name _____________________________________ Mother's Age __________
Father's Name ______________________________________ Father's Age __________

If parents are separated or divorced, when did this occur?
(MM/YYYY) _____________ and how old was the adolescent (_____ yo).

Please list all family members currently living at home or closely connected with the family. Include parents who are currently living with the adolescent.

NAME	AGE	RELATIONSHIP TO ADOLESCENT	GRADE OR OCCUPATION

How does this adolescent get along with his/her brothers and/or sisters?
____
____
____

Describe any special activities that you do with this adolescent.
____
____
____

List what you believe to be the adolescent's main difficulties at home.
1) ____
2) ____
3) ____

In your opinion, how much (by percentage) do others (by name or relationship) I the home contribute to the difficulties the adolescent is experiencing? (For example, 25% of the problem is dad's parenting style, 25% is mom failing to enforce the house rules, etc.)

____
____
____

Describe *how* this adolescent is disciplined.

____
____
____

For what reasons is the adolescent disciplined?

____
____
____

SOCIAL DEVELOPMENT AND PEER RELATIONSHIPS

What special interests, hobbies, sports, and games does the adolescent enjoy, both in and after school?

____
____
____
____

When this adolescent chooses playmates, are they (Check all that are appropriate):
□Older □Younger □Own Age □All Ages
□Boys □Girls □Both Boys and Girls

In his/her activities, is the adolescent a leader, a follower, or a loner? ___________________

Does the adolescent prefer the company of adults to other adolescents? □ Yes □ No

Does the adolescent have at least one best friend? □ Yes □ No

What is the friend's first name and age?

____ Age _________

Does the adolescent date? □ Yes □ No Is the adolescent sexually active? □ Yes □ No

Does this adolescent have a boyfriend or a girlfriend? □ Yes □ No

What's the first boyfriend/ girlfriend's name and age? ______________________________

Does the adolescent attend church regularly? □ Yes □ No If yes, where? _______________

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EMOTIONAL DEVELOPMENT

Has your adolescent ever been characterized by family members, teachers, or others as being:

Restless/Inattentive	□ Yes □ No	Daydreamer	□ Yes □ No
Forgetful	□ Yes □ No	Disruptive	□ Yes □ No
Humorous/Fun	□ Yes □ No	Immature	□ Yes □ No
Quick to Anger	□ Yes □ No	Happy	□ Yes □ No
Cheerful	□ Yes □ No	Aggressive	□ Yes □ No
Depressed/Sad	□ Yes □ No	Nervous/Tense	□ Yes □ No

Does this adolescent have a great many fears or worries? If so, what are they?
____
____
____

Does the adolescent have recurring nightmares or night terrors? If yes, describe the nature of the dream content.
____
____
____

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Has the adolescent ever been the victim of perpetrator of physical, emotional, verbal, or sexual abuse? If yes, please describe the nature of the abuse and when it occurred. If no, please skip to the next section (**SCHOOL HISTORY**)

If physical or sexual abuse occurred, was the abuse reported to the Department of Family and Child Protective Services (CPS)? □ Yes □ No
Does this adolescent have an open CPS case file? □ Yes □ No

If yes, what is the case number and who is the CPS case manager?
____
____
____
____
____

Has this adolescent ever received formal counseling for the abuse? □ Yes □ No
If yes, who was the counselor, how long was he/she in therapy, when did the counseling end, and what was the outcome of therapy?
____
____
____
____

SCHOOL HISTORY

Briefly describe how the adolescent is doing in school. Note areas of strength **and** weakness in school (Academic, social, etc.).

____
____
____
____
____
____

Is the adolescent reading at appropriate grade level? □ Yes □ No

What is the adolescent's current reading level? ____________________________________

Has the adolescent ***ever*** failed a standardized test? □ Yes □ No

If yes, which one(s) and what year of school?

____
____
____

Has the adolescent ever been diagnosed by **competent** (licensed) medical or behavioral health professional with a learning disability? □ Yes □ No
If yes, which one(s), at what age was the diagnosis made, and who made the diagnosis?

____
____
____

Has the adolescent ever been diagnosed by **competent** (licensed) medical or behavioral health professional with ADHD? □ Yes □ No
If yes, which subtype, at what age was the diagnosis made, and who made the diagnosis?

____
____

What report card grades, and standardized (TAKS) test scores, does the adolescent usually achieve?

____
____
____

Have these changed lately? □ Yes □ No
If yes, how?

____
____
____

Explain the circumstances ***if*** this adolescent has:
1) Had extended or frequent absences

____
____
____

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2) Had to repeat the academic year

____
____
____

3) Changed schools in mid-year

____
____
____

4) Began the school year at a new school

____
____
____

Has he/she had any remedial help or special education services in school or privately?
□ Yes □ No If yes, please describe and give approximate dates.

____
____
____

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Has he/she been granted Section 504 educational benefits/services due to an identified disability (including ADHD, learning disability, dyslexia, dyscalculia, or physical disability)?
□ Yes □ No

Please describe this adolescent's attitude toward school. Note any special interests or dislikes he/she has in school.

____
____
____

How does this adolescent get along with the teacher and other students in school?

____
____
____

List the adolescent's main difficulties at school.

____
____
____

MEDICAL HISTORY

Name of adolescent's pediatrician/ family physician: ________________________________
Phone (if known): ____________________

What was the approximate date of the adolescent's last physical exam?
____

Please describe this adolescent's general health.
____
____
____

Has he/she had any serious illnesses, accidents, or injuries?
____
____
____

Has he/she ever been treated for a psychiatric or substance use problem? □ Yes □ No
If yes, when, where, for what problem, and who provided treatment.
____
____
____
____
____

Please give reasons and approximate dates for any hospitalizations (for any reason).
____
____
____
____

Are there any conditions that require regular medical care?
____
____
____
____

Does this adolescent take any medications on a regular basis? If so, please note type of medication, frequency of use, and the physician who prescribed the medication.
(Use the reverse of the form if there is not sufficient space.)

Medication	Dosage (mg)	Frequency	Reason Of Taking The Medication	Physician

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Does this adolescent take any supplements, including vitamins, on a regular basis? If so, please note type of supplement and frequency of use.

Supplement	Dosage (mg)	Frequency	Reason Of Taking The Medication

Does the adolescent have any difficulties with vision or hearing? Note date and results of any previous vision or hearing examinations.

____
____
____
____
____
____

Does the adolescent have any allergies (including food and medication allergies)?
□ Yes □ No
If yes, please identify.

____
____
____

Are you aware of any struggles your adolescent has with body image? □ Yes □ No
If yes, please identify.

____
____
____
____
____

Are you aware of any struggles your adolescent may have with eating? □ Yes □ No
If yes, please identify.

____
____
____
____
____

Please give any additional information that you believe would be helpful.

____
____
____
____
____
____
____

Thank you for completing this form carefully and thoroughly – the information you provide will be invaluable as we work with your adolescent!

Thank you for Choosing Focus for Living!

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INFORMATION ABOUT THERAPEUTIC SERVICES

WHO WE ARE

Focus for Living, PLLC is a faith-based, private counseling practice. We are committed to providing counseling that is based on biblical Christian principles in a comfortable, confidential atmosphere with Christian counselors who integrate therapeutic skills with a solid biblical foundation.
Focus for Living offers professional therapeutic programs designed to offer a wide variety of counseling services. We are here to serve individuals and their families in northern Johnson and southern Tarrant counties as well as the larger military community (active duty, reserves, retired, and military family members). Services are provided by licensed mental health professionals, trained in individual, marriage, and family counseling, and neurotherapy (also referred to as neurofeedback or EEG biofeedback). In addition, we have licensed professional counselor interns who are completing their required hours of clinical supervision under the direct supervision of Dr. Wesley D. Center, LPC (Board Approved Supervisor), NCC, BCPCC who is licensed by:

Texas State Board of Examiners of Professional Counselors 512-834-6658
(The above Texas State Board receives questions and complaints regarding services by licensed professionals at the indicated number. Services are available to the hearing and speech impaired through Relay Texas: 800-735-2989.)

CONFIDENTIALITY

It is important for you to understand that all identifying information about your counseling therapy treatment is kept confidential. Even within the practice, information regarding your case is only shared with those professionals (i.e., supervisors and peer consultants) who will confer with your service provider and thereby enhance the services you receive. We routinely consult with peers in our field of counseling, psychotherapy, and neurotherapy related to our cases. Client confidentiality is maintained throughout the process of consultation and no personally identifying information is shared with peer consultants.

In order to protect client confidentiality, we adhere to the following procedures:

1. Written, telephone, or personal inquiries about clients will not be acknowledged without permission. You must sign a release before any information about you is given to anyone outside the counseling center. Even then we may advise you to withhold information if we feel it is in your best interest.

2. All records or other identifying materials are kept confidential.

3. EEG and Neurofeedback recordings are routinely erased and records are destroyed on a regular basis as provided for in Texas law.

4. Legal limits to confidentiality are observed.

INFORMATION ABOUT THERAPEUTIC SERVICES (Continued)

Service Policy

Calls placed to Focus for Living are primarily for the purpose of scheduling or rescheduling appointments. Non-emergency calls received will be returned within 24 hours Monday through Thursday. Calls placed Friday through Sunday will be returned by the following Tuesday. In emergency situation (i.e., situations where someone is out of control, has ideas or plans of self-harm or of harming others, or demonstrates potentially harmful behavior) the client should dial 911 or go directly to the nearest hospital emergency room.
When a cancellation of a counseling session is unavoidable, it is important for the client to notify the counselor 24 hours in advance. *Failure to provide 24 hours notice, or no-shows for appointment, will result in the client being billed for the full amount of the missed appointment.* Consistently missed appointments (barring bona fide emergencies), failure to work toward goals for counseling, failure to complete counseling homework assignments on a regular basis, or use of drugs or alcohol prior to an appointment may result in termination of the counseling relationship.

"I have read and understand the confidentiality and service policies of *Focus for Living* and I give my therapist permission to consult with peers regarding my case, if my therapist deems it necessary, during the course of therapy. I understand that I will be charged for missing appointments without canceling at least 24 hours in advance. I also understand that failure to attend, failure to participate in session or complete out of session assignments, or using drugs or alcohol prior to a session may result in termination of the counseling relationship."

X ______________________ ______________________ ______________________
Signatures of Parents or Guardians Date

______________________ ______________________
Printed Names of Parents or Guardians

X ______________________________________ ______________________
Staff Signature Date

____
Staff's Name (Print)

Financial Arrangements

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, personal checks, MasterCard, Visa, American Express, and Discover. Returned checks, late cancellations, missed appointments, and balances older than 30 days are subject to additional collection fees.

The FULL FEE will be charged for all late cancellations or missed appointments.
Please note: REMOTE CREDIT CARD CHARGES INCUR A 10% (TEN PERCENT) HANDLING FEE BY THE CREDIT CARD PROCESSING COMPANY.

We are in network with Blue Cross/Blue Shield. Please note that insurance companies require the therapists to provide them with your diagnosis, medication, and compliance to treatment. Insurance does not guarantee coverage of treatment. If insurance does not cover the cost of treatment, you are responsible for full payment of services.

IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION, PLEASE DO NOT HESITATE TO ASK US.

I understand that my card will be immediately charged the full fee for appointments cancelled or missed without 24 hours' notice given. Insurance does not guarantee coverage of treatment. If insurance does not cover the cost of treatment, I understand that I am responsible for full payment of services. Furthermore, I understand that remote credit card charges incur a 10% (ten percent) handling fee by the credit card processing company. I also understand that Focus for Living will notify me prior to charging the card listed below, and will provide a receipt of the transaction.

I attest that I agree to this document, and all the information provided is accurate to the best of my knowledge. I further attest that I am allowed to all the rights and privileges that are associated with this card.

X ______________________ ______________________ ___________________________
Signatures of Parents or Guardians Date

________________________ ______________________
Printed Names of Parents or Guardians

Credit Card on File Authorization (Required)

Focus for Living requires that a credit card be kept on file for your convenience and/or in the event of unpaid balances, late cancellations or missed appointments.

Information to be completed by the card holder:

Cardholder Name: (as appeared on card): ____

Billing Address: ____

Card Number: ____

Security Code: _________________ (3 digit code on back or 4 digit code on front) Expiration Date: _____________

Card Type: Visa MasterCard Discover American Express

E-mail (where receipts will be sent): ____

I, ______________________________________, authorize *Focus for Living* to charge the credit card account ending in __ __ __ __ for counseling services and related fees.

X ____ ____________________
Cardholder Signature Date

INSURANCE INFORMATION

(Self-pay clients: Please skip to the next page.)

Full Name of the **Primary Insured Subscriber**[1] ___________________________ MI: ____

Patient Relationship to the Primary Insured Subscriber:

□Self □ Spouse □ Child □Other: _____________________

Subscriber/ Member ID: __________________________________

Date of Birth of the Primary Insured Subscriber: _____________________________

Group Number: ___________________ Plan Name: ______________________________

Deductible: ____________ How much of the deductible has been met? _____________

Address ____

City ____ State ________ Zip _________

Cell Phone /Other _________________________ Work Phone ___________________

***Insurance does not guarantee coverage of treatment. If insurance does not cover the cost of treatment, you are responsible for <u>full payment of services</u>.** For more information on financial arrangements, please see page 15, **Financial Arrangements**.

If you would like to enquire more detailed information about the coverage of specific services, please feel free to call us at 817-295-8708.

[1] Please be sure to bring along with your Driver's License and your insurance card for the first day of your visit. Thank you!

LIMITATIONS OF CLIENT-THERAPIST CONFIDENTIALITY

Confidentiality is of the utmost importance where the client-therapist relationship is concerned. We believe that it is important that the client be able to assume that their private communications with the therapist be kept private. However, there are certain exceptions which supersede the confidentiality of the client-therapist relationship. It is our ethical obligation to inform you of the exceptions.

Exceptions to the Limits of Confidentiality:

1. The therapist makes an assessment of an impending suicide risk.

(Chapter 611, Family Code)

2. A client reports past or present instances of the abuse or neglect of a child, elderly person, or mentally challenged person. (Chapter 261, Family Code)

3. A client acknowledges committing abuse or neglect of a child, elderly person or mentally challenged person either in present or in the past. (Chapter 261, Family Code)

4. There is a probability of imminent harm to the client or others. (Chapter 611, Sec. 004(a)(2) Health and Safety Code)

5. Counseling records may be released when they are subpoenaed by a court of law.

I have read the preceding statement and understand that under the above stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances my therapist is bound ethically and legally to inform the proper authorities.

X ______________________ ______________________ ______________________
Signatures of Parents or Guardians Date

______________________ ______________________
Printed Names of Parents or Guardians

X ____ ______________________
Staff Signature Date

____
Staff's Name (Print)

CONSENT FOR COUNSELING MINORS

Minor's Name: _________________________ Date of Birth: ___________________ Age: _____

Address: _____________________________________ Phone Number: ____________________

This is to certify that I give permission to *Focus for Living*, PLLC for the treatment of my child. I further certify that I am either:

the natural parent of my child with **full custody**;
the court appointed managing conservator of the above child;
the custodial parent of the above child with authority to make medical decisions for the child; or,
a joint custodian of the above child.

This counseling may include individual or group psychotherapy, counseling, neurotherapy (EEG biofeedback) and testing. This counseling may include consultations with other associates of this practice.

This counseling may also include referrals to other appropriate State and County or professional agencies for further counseling.

Payment Agreement: _______________________ **Paid:** ____________________

X ____________________ ____________________ ________________________
Signatures of Parents or Guardians Date

____________________ ____________________
Printed Names of Parents or Guardians

X ____ ________________________
Staff Signature Date

____
Staff's Name (Print)

MINOR'S INFORMED ASSENT TO COUNSELING

I understand that when I come to my counselor's office I will be talking and doing other things that will help me to find answers to some of my questions and solutions for my problems. Because this office is a safe place I can talk about anything that I want to. I can talk about myself and my family. I can even talk about the things that worry me. If I don't feel like talking, I don't have to, but I understand that talking will help my counselor to help me. Sometimes when I come here, I will feel a lot better. Sometimes I might feel a lot worse before I will feel better.

Sometimes my counselor will have my whole family in the room to talk about things going on in our family. When we meet as a family I understand that what I have to say is important, but so are the things that my siblings (brothers and sisters) and parents have to say. I understand that I need to listen and talk whenever we meet with my counselor as a family.

Sometimes my counselor may ask me to do things at home and then bring them back with me later to talk about. Sometimes the things I am asked to do at home may involve other family members including my parents. I know these things that my counselor asks me to do are to help them learn more about me, my family, and how I am doing.

My parents will know if I am doing better or not. My counselor might give my parents ideas on how to help me with problems. If my counselor wants to talk about me with another person, my counselor will ask my parents and me for our permission. My counselor will have to talk to other people if I say that someone is hurting me or doing things to me that they shouldn't. Also, if I say that I want to hurt myself, then my counselor will have to tell someone.

I am signing my name on this paper to show that I agree to talk to my counselor and do the things my therapist may ask me to do at home or here in the office.

X ____ ___________________________
Signature of Minor Date

____
Printed Name of Minor

X ____ ___________________________
Staff Signature Date

____
Staff's Name (Print)