Focus for Living, PLLC
308 East Renfro, Suite 202
Burleson, Texas 76028
817-295-8708

Office Use Only			
ID#	Intake Date:	Therapist:	
Hourly Fee:	Previous Client: Y/ N	Previous Date of FFL Service:	
PW Signed □	Copy of DL □	Payment Rvd □	Face Sheet □

Adult 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.

CLIENT CONTACT INFORMATION

Full Name _____

Date of Birth _____ Age _____ □ Male □ Female

Address _____

City _____ State _____ Zip _____

Cell Phone /Other _____ Work Phone _____

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

Who should we contact in case of emergency?

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____

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Adult Intake Information

GENERAL INFORMATION

First Name _____ Last Name: _____ MI: ___

Date of Birth _____ Age _____ □ Male □ Female

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

City _____ State _____ Zip _____

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

Cell Phone /Other _____ Work Phone _____

May we **text** your cell? □ Yes □ No May we **email** you? □ Yes □ No
Email Address: _____

Race _____ Handedness: Right / Left / Ambidextrous
Preferred Spoken Language: _____ First Language Spoken: _____

FAMILY INFORMATION

Current Marital or Significant Other Status:

□ Never Married □ Married □ Cohabitating □ Divorced □ Separated □ Widowed

Name of Spouse/ Partner: _____
Date of Marriage (MM/DD/YYYY): _____ (If Applicable)
Spouse/ Partner's phone number _____
Date of Marriage (MM/DD/YYYY) _____

Previous Marital/ Significant Relationship History: (if applicable)

Self:

Name of Previous Spouse/ Partner	Date of Marriage	Date of Divorce/ Separation/Death

(Use the back of the form if more space is needed)

Spouse:

Name of Previous Spouse/ Partner	Date of Marriage	Date of Divorce/ Separation/Death

(Use the back of the form if more space is needed)

Children: (Biological/Adopted/ Foster)

Name	Sex	Age	Father's/Mother's First Name

EDUCATION

Total Years of Education: _____ (number of years including 12th grade or under)

Your Education Level:

□ GED □ High School Diploma □Some College

□ College Degree(s) Field: _____

□ Graduate Degree(s) Field: _____

Spouse's Education Level:

□ GED □ High School Diploma □Some College

□ College Degree(s) Field: _____

□ Graduate Degree(s) Field: _____

Occupation/ Place of Current Employment _____

OCCUPATIONAL INFORMATION

Occupation/ Place of Current Employment _____

Current Employment Status:

□Full-Time □Part-time □Unemployed □Unemployed because of Pain

□Homemaker □Retired □Student

PERSONAL INFORMATION

Are you currently attending a church? □ Yes □ No

If yes, what is the name of the church? _____

What is the denomination of the church? _____

How important (Scale 1-10; 1-Not important at all, 10- Most important) religious or spiritual issues important in your life? _____

Do you have any religious or spiritual resources in your life that could be used to help you overcome your problems? □ Yes □ No

If yes, what are your spiritual resources? _____
_____
_____

In your personal opinion, what do you understand that it takes for a person to get to heaven? _____
_____
_____
_____

Who referred you to our practice? _____

Health Concerns

How would you rate your health?
□ Very Healthy □ Healthy □ Average □ Unhealthy □ Poor Health □ Terminally Ill
How many hours of restful sleep do you get each night?_____
How long does it typically take for you to fall asleep? _____
If you wake up during the night, how long does it typically take for you to fall back to sleep? _____
Describe your bedtime routine: _____
How many times per week do you exercise?_____
What form(s) of exercise do you engage in? _____
Do you experience food cravings? □ Yes □ No

If so, for what items? _____
_____
_____

How would you rate your diet?
□ Very Healthy □ Healthy □ Average □ Needs Improvement □ Poor □ Don't Know

Medical Information

Do you have any medication, food or environmental allergies? □ Yes □ No
If yes, please list:_____
_____

Aside from you pain problem (if applicable), how is your general health (please check one)?
□Excellent □Minor Health Problems Only □ Major Health Problems

Have you had any of the following health problems (please check all that apply)
□ High blood pressure □ Diabetes □ Heart Problems □ Needs Improvement □ Poor

Do you take any medications on a regular basis? If so, please note type of medication, frequency of use, and the physician who prescribed the medication.

Medication	Dosage (mg)	Frequency	Reason Taking this Medication	Physician

Do you 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 Taking this Supplement

Do you use any energy drinks or caffeinated beverages on a regular basis? If so, please note type of beverage and frequency of use.

Beverage	Amount (oz)	Frequency	Perceived Benefit of Use (feel alert / energy)

PERSONAL CONCERNS

What are you seeking help for? _____

_____

_____

_____

_____

How much are you troubled by this concern?

□ Constantly □ Often □ Somewhat □ Not Very Much □ Not at all

Comments concerning this problem: _____

_____

_____

_____

_____

Have you been in formal counseling before? □ Yes □ No
If so, for each incidence you remember, please complete the following (use back of this page if needed.)

Who was the counselor? _____
What was the nature of the problem? _____
How many sessions over what period of time? _____
What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless.	□ Never	□ Rarely	□ Sometimes	□ Frequently
2. I am lonely.	□ Never	□ Rarely	□ Sometimes	□ Frequently
3. No one cares about me.	□ Never	□ Rarely	□ Sometimes	□ Frequently
4. I am a failure.	□ Never	□ Rarely	□ Sometimes	□ Frequently
5. Most people don't like me.	□ Never	□ Rarely	□ Sometimes	□ Frequently
6. I want to die.	□ Never	□ Rarely	□ Sometimes	□ Frequently
7. I want to hurt someone.	□ Never	□ Rarely	□ Sometimes	□ Frequently
8. I am so stupid.	□ Never	□ Rarely	□ Sometimes	□ Frequently
9. I am going crazy.	□ Never	□ Rarely	□ Sometimes	□ Frequently
10. I can't concentrate.	□ Never	□ Rarely	□ Sometimes	□ Frequently
11. I am so depressed.	□ Never	□ Rarely	□ Sometimes	□ Frequently
12. God is disappointed in me.	□ Never	□ Rarely	□ Sometimes	□ Frequently
13. I can't be forgiven.	□ Never	□ Rarely	□ Sometimes	□ Frequently
14. Why am I so different?	□ Never	□ Rarely	□ Sometimes	□ Frequently
15. I can't do anything right.	□ Never	□ Rarely	□ Sometimes	□ Frequently
16. People hear my thoughts.	□ Never	□ Rarely	□ Sometimes	□ Frequently
17. I have no emotions.	□ Never	□ Rarely	□ Sometimes	□ Frequently
18. Someone is watching me.	□ Never	□ Rarely	□ Sometimes	□ Frequently
19. I hear voices in my head.	□ Never	□ Rarely	□ Sometimes	□ Frequently
20. I am out of control.	□ Never	□ Rarely	□ Sometimes	□ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the space on the additional page for your response if needed.

_____
_____
_____
_____
_____

SYMPTOMS

Please check the behavior and symptoms that occur to you more often than you would like for them to take place.

□ Aggression	□ Fatigue	□ Sexual Difficulties
□ Alcohol Dependence	□ Hallucinations	□ Sick Often
□ Anger	□ Heart Palpitations	□ Sleeping Problems
□ Antisocial Behavior	□ High Blood Pressure	□ Speech Problems
□ Anxiety	□ Hopelessness	□ Suicidal Thoughts
□ Avoiding People	□ Impulsivity	□ Thoughts Disorganized
□ Chest Pain	□ Irritability	□ Trembling
□ Depression	□ Judgment Errors	□ Withdrawing/Isolating
□ Disorientation	□Loneliness	□ Worrying
□ Distractibility	□ Memory Impairment	□ Other (Specify)
□ Dizziness	□ Mood Shifts	_____
□ Drug Dependence	□ Panic Attacks	_____
□ Eating Disorder	□ Phobias/Fears	_____
□ Elevated Mood	□ Recurring Thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.) Use the back of this sheet if necessary. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PERSONAL RISK ASSESSMENT

Have you *ever* been diagnosed with one or more of the following?

□ Major Depression □ Alcohol Dependence □ Drug Dependence

□ Schizophrenia □ Bipolar Disorder □ Chronic Pain

□ PTSD □ ADD/ADHD □ Anxiety Disorder

□ Night Terrors □ Nightmare Disorder

Have you ever been hospitalized for a psychiatric disorder? □ Yes □ No

If yes, how many times, when, and briefly, what were the circumstances?

_____
_____
_____
_____

Have you *ever* attempted suicide? □ Yes □ No

If yes, how many times, when, and briefly, what were the circumstances?

_____
_____
_____
_____
_____

Have you ever cut or otherwise harmed yourself? □ Yes □ No

If yes, when, how, and what triggered your self-harm? _____
_____
_____
_____
_____
_____
_____

Do you have a family history of self-harm or harming others? □ Yes □ No

If yes, what was his/her/their relationship to you? _____
_____
_____
_____
_____

What harmful behavior(s) was/were involved? _____
_____
_____
_____
_____

Do you have access to guns or other weapons in your home? □ Yes □ No

Do you have access to lethal amounts of medications? □ Yes □ No

Do you have a family history of substance abuse/dependence? □ Yes □ No

If yes, what was his/her/their relationship to you? _____
_____
_____
_____

What substance(s) was/were involved? _____
_____
_____

What is your personal history with drugs and/or alcohol?

SUBSTANCE	ROUTE (ORAL, IV, etc)	AGE AT 1ST USE	AVERAGE AMOUNT USED	FREQUENCY	LAST TIME YOU USED
Alcohol					
Marijuana					
Cocaine					
Heroin					
Hallucinogens					
Benzodiazepines					
Opiates/Opioids					
Inhalants					
Barbiturates					
Amphetamines					
Tobacco					
Other, specify					
Other, specify					

What do we need to know about you that we haven't asked you on this form?
_____
_____
_____
_____
_____

Thank you for choosing
Focus for Living

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 _____ _____

Client Signature Date

_____

Client's Name (Print)

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 _____ _____
Client Signature Date

_____
Client's Name (Print)

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 _____ _____
Client Signature Date

_____
Client's Name (Print)

X _____ _____
Staff Signature Date

_____
Staff's Name (Print)

INFORMED CONSENT FOR COUNSELING

I understand that counseling may involve discussing relationship, spiritual, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. I am further aware that *Focus for Living*, PLLC is a faith-based, private counseling practice. I am aware that there are alternative treatment facilities available to me.

My therapist has satisfactorily answered all of my questions about counseling at *Focus for Living*, PLLC. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best accomplished in consultation with the therapist.

In signing this form:

a) I understand and agree to the services at this center being provided by licensed mental health professionals. Any questions may be addressed to Dr. Wesley D. Center, President, *Focus for Living*, PLLC at 817-295-8708.

b) I understand the confidentiality policies of *Focus for Living*, PLLC and I agree to them.

d) I understand that my role as a client is:

1) To be honest during counseling sessions, to complete homework assignments, and to demonstrate a willingness to change.

2) To refrain from the use of alcohol or drugs prior to a counseling session.

Payment Agreement: _____ **Paid:** _____

X _____ _____
Client Signature Date

_____
Client's Name (Print)

X _____ _____
Staff Signature Date

_____
Staff's Name (Print)