



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

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

Child 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]

CHILD'S PSYCHOSOCIAL HISTORY

FAMILY HISTORY

Date: _____

Child'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 child (_____ yo).

Please list all family members currently living at home or closely connected with the family.

Include parents who are currently living with the child.

NAME	AGE	RELATIONSHIP TO CHILD	GRADE OR OCCUPATION

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

Describe any special activities that you do with this child. _____

List the child's main difficulties at home.

- 1) _____
- 2) _____
- 3) _____

Describe *how* this child is disciplined. _____

For what reasons is the child disciplined? _____

SOCIAL DEVELOPMENT AND PEER RELATIONSHIPS

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

When this child chooses playmates, are they (Check all that are appropriate):

- Older Younger Own Age All Ages
 Boys Girls Both Boys and Girls

In play activities, is the child a leader, a follower, or a loner? _____

Does the child prefer the company of adults to other children? Yes No

Does the child have at least one best friend? Yes No

What is the friend's first name and age?

_____ Age _____

Does the child attend church regularly? Yes No If yes, where? _____

EMOTIONAL DEVELOPMENT

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

- | | | | |
|----------------------|--|---------------|--|
| Restless/Inattentive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Daydreamer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Forgetful | <input type="checkbox"/> Yes <input type="checkbox"/> No | Disruptive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Humorous/Fun | <input type="checkbox"/> Yes <input type="checkbox"/> No | Immature | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Quick to Anger | <input type="checkbox"/> Yes <input type="checkbox"/> No | Happy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cheerful | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aggressive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depressed/Sad | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Tense | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

Does the child have unusual or persistent nightmares? If so, what are they about?

SCHOOL HISTORY

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

Is the child reading at appropriate grade level? Yes No

What is the child's current reading level? _____

Has the child **ever** failed a standardized test? Yes No

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

Has the child 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 child 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 child usually achieve?

Have these changed lately? Yes No

If yes, how?

Explain the circumstances **if** this child has:

1) Had extended or frequent absences

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.

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 child's attitude toward school. Note any special interests or dislikes he/she has in school.

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

List the child's main difficulties at school.

MEDICAL HISTORY

Name of child's pediatrician/ family physician: _____

Phone (if known): _____

What was the approximate date of the child's last physical exam? _____

Please describe this child's general health.

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

Please give reasons and approximate dates for any hospitalizations.

Are there any conditions that require regular medical care?

Does this child 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

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

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 _____
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 full payment of services.** 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 therapist's office I will be playing, drawing, and talking. I can talk about anything that I want to. I can talk about myself and my family. I can even talk about my worries, if I want to. If I don't feel like talking, I don't have to. Sometimes when I come here, I will feel a lot better. Sometimes I might feel a lot worse before I will feel better. During play, I can do anything I want if I follow three rules. I will respect myself, my brothers or sisters, and my therapist. I will not hurt my therapist. I will not break any of the toys on purpose.

Sometimes my therapist 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 therapist as a family.

Sometimes my therapist 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 therapist ask 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 therapist might give my parents ideas on how to help me with problems. If my therapist wants to talk about me with another person, my therapist will ask my parents and me for our permission. My therapist 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 therapist will have to tell someone.

I am signing my name on this paper to show that I agree to talk to my therapist and do the things he or she 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)