

Today's Date: _____ Please complete ALL areas. If not applicable, write "NA".

Clifton Fuller, LCSW, LPC, LMFT

15303 Huebner Rd #10, San Antonio, TX 78248 210-404-9001

CONFIDENTIAL CLIENT INFORMATION

Client Information

Spouse (or Guardian Information)

CLIENT Name: First Middle Last

Address (Street/Apt #):

: City 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
 Single Married Separated Divorced Widowed Other:

Name: First Middle Last

Address (Street/Apt #):

: City 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
 Single Married Separated Divorced Widowed Other:

If client is under 18, Information on other guardian/parent:

Other parent/guardian's Name: First, Middle, Last name

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: _____

Other family members living in home of client (use reverse side of this page for additional info):

1. Name: First/Last Relationship to client: _____ DOB (or age) _____

2. Name: First/Last Relationship to client: _____ DOB (or age) _____

3. Name: First/Last Relationship to client: _____ DOB (or age) _____

4. Name: First/Last Relationship to client: _____ DOB (or age) _____

5. Name: First/Last Relationship to client: _____ DOB (or age) _____

Client Name: _____

Billing Information

Responsible Party for Payment Relationship to Client Phone

Address City State Zip Additional Phone

Indicate method of payment for services: Clients & all responsible parties understand they're responsible for any/all services provided through our offices, including but not limited to counseling, consultations, School ARD's, telephone or emergency calls, late cancels, no-shows, fees related to collection of account due to non-payment, including fees added by collection agencies. By seeking services client indicates intent to keep account in good standing (paid in full).

- Self-Pay--I will pay in full at the time of service.
- If I have or obtain insurance, I will bill my own insurance & pay at the time of service (re New Client Info brochure for additional information. Request forms from Mr. Fuller to include with your insurance filing and expedite your insurance company's reimburse directly to you.)

Payments made by: Cash Credit Card Check (\$35 returned check fee)

Insurance Information (We must have copy of back & front of insurance card to bill insurance)

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

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

Financial Agreement (By seeking services, I agree to the following)

By seeking services....**I agree and understand I will be charged a \$50 fee for the first session not cancelled 24 hours in advance, \$100 fee for second missed/late cancellation, and full fee for all other late cancel/no show appointments.
 **Individual sessions are 45-50 minutes. Family/Marital is 50 minutes-1 hour. Additional fees apply if sessions exceed allowed times.
 **I received, read and agree to terms listed in the New Client Brochure for this professional's office.
 **If provider's office files insurance claims, I authorize billing entities to release necessary information to insurance carrier to process claims.
 **I understand I am responsible for any & all payments. I certify information provided on this form is accurate, true and complete.

Client Signature Date Parent/Guardian/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 upon request. I certify I have reviewed the Federal HIPPA Ruling provided by this office.

Client Signature Date Parent/Guardian/Spouse Signature Date

CLIENT NAME: ----- **Person filling out this form:** _____

If you aren't the client, but want to share your assessment of the situation with Mr. Fuller, please make additional copy of this page, fill out this form's top section & give to Clifton Fuller at beginning of initial appointment. You may also fax it to our offices at 888-599-1976.

Current Symptoms: Please rate all that apply from 0 to 3 (0-None 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:

YES	NO	Any Major Illnesses:
YES	NO	Has client exhibited physical aggression or threats of harm toward others?
YES	NO	Has client exhibited behaviors cruel to animals? If yes, please explain:
YES	NO	Has client shown destructive tendencies toward property (setting fires, vandalism, property/home destruction)?
YES	NO	Has client had history of employment changes (repeated job losses, difficulties, etc.)?
YES	NO	Has client been in trouble with the law repeatedly or with law enforcement groups?
YES	NO	Has client been truant from school on repeated occasions?
YES	NO	Does client have addictions? (drug, alcohol, pornography, gambling, computer, or other addictions)
YES	NO	Does client smoke? If yes, how much per day?
YES	NO	Does client drink alcoholic beverages? If yes, how much per day?
YES	NO	Has client used inhalants not medically prescribed (now or in the past)?
YES	NO	Military history? (list military service/discharge type) Post Traumatic Stress?
YES	NO	List major traumas (Abuse, Violence, Loss of child/spouse/ friend, Robbery, Feared Death Experiences)
YES	NO	Has client had legal issues, past & present which may affect service?
YES	NO	Has client exhibited inappropriate sexual behaviors?
YES	NO	Developmental problems in infancy, childhood or adolescence? (Hearing/speech problems, difficulty walking, surgeries, pre-mature birth, learning disabilities, etc.)
YES	NO	Other situations, experiences or concerns of which therapist should be aware?