Sharp Family Services, LLC

Counseling, Education, Criminal/Family Court Services

3300 Sundown Blvd., Denton, TX 76210
P-940.312.7022/F-214-614-4046

Date:________________________________ Referred By:______________________________________

Name:____ Sex: ____ Male ____ Female

Address:_______________________________ City:_______________________ State: ____ Zip:_____________

Email Address:____

Age: ____ Birth Date: ____/____/_______ Social Security Number: _XXX_-_XX_-_______

Home Phone:___________________________________
May we leave a message at your home? ____ Yes ____ No

Cell Phone:_____________________________________
May we leave a message on your cell? ____ Yes ____ No

Work Phone:___________________________________
May we leave a message at yourwork? ____ Yes ____ No

Attorney Name/# (if applicable):____

Name/Birth Date/Age of Client(s) – ***if different from above:***

____

Level of Education:______________________________ Employer:_________________________________

How long? ______________________________ Occupation:____

Marital Status:_____________________ How long? __________ Spouse's Name:________________________

Spouse Employed By:____

Emergency Contact:______________________________________ Phone:_______________________________

Church Attended/Religious Preference:____

Names and Ages of All Persons in Home:____

____

What concerns bring you to counseling at this time? ___________________________________

____

What changes would you like to see as the result of counseling? ____________________________

____

Please list any previous counseling experiences:

1. ____ Helpful? ____ Yes ____ No

2. ____ Helpful? ____ Yes ____ No

Past Hospitalizations – Medical, Psychiatric, Chemical Dependency:

Dates:____________________ Hospital:________________________________ Reason:____________________

Dates:____________________ Hospital:________________________________ Reason:____________________

Are you under a doctor's care? ____ Yes ***If yes,*** name/phone #:______________________________

List any current medications/medical conditions:

____

Please list any legal history (offenses/arrests/charges/dispositions):

____

____

Please circle ALL items currently a concern to you regarding ***YOU/YOUR PRESENT RELATIONSHIP.***

1. Premarital Counseling
2. Marital Relationship
3. Remarried Relationship
4. Poor Communication
5. Sexual Difficulties
6. Parenting Concerns
7. Anxiety/Depression
8. Family Relationships
9. Alcohol/Drug Abuse
10. Stress/Anger
11. Self-esteem
12. Physical Problem
13. Suicidal Thoughts/Attempt
15. Childhood Emotional/Sexual Abuse
16. Financial Concerns
17. Death/Loss/Grief
18. Work-related Concerns
19. Verbal Abuse/Violence
20. Trauma
21. Divorce Contemplation/Recovery
22. Other (*please describe*) ____

Please circle ALL items that are currently a concern to you regarding ***YOUR CHILD.***

1. School Issues/Truancy
2. Physical Violence
3. Drugs/Alcohol
4. Sexual/Physical Abuse
5. Family Dynamics
6. Death/Loss/Grief
7. Anger/Depression/Self-esteem
8. Peer Relationships
9. Other (*please describe*) ____

How did you hear about Sharp Family Services, LLC?

_____ Internet/Yellow Pages _____ Brochure _____ Church _____ Doctor _____ Friend _____ Attorney

May we send the person who referred you a "Thank You" for the referral? ____ Yes ____ No

If yes, please provide the referring person's name and address below:

____

____

Any suspected violations of a licensed counselor's ethics may be reported to the following governing agency:

Texas Behavioral Executive Council
LPC Licensure Board
800-821-3205

I give Sharp Family Services, LLC, consent to provide assessment/treatment/referral services for me/my children's specific needs. In the event I need to cancel or reschedule my appointment, I understand 24-hour notice is required. If I'm unable to provide that notice, I understand I will be charged a fee. Though SOME services provided by a licensed counselor are reimbursable by insurance, court-ordered services are typically not covered by insurance. I understand that SFS does not file insurance claims for clients. My licensed therapist can provide necessary insurance forms with appropriate diagnostic/procedural codes within 10-days of service. However, I am responsible for my balance regardless of insurance/3rd party reimbursement. I am responsible for paying all fees at the time services are rendered. I understand any unpaid balance (for no-shows/late cancellations/NSF charges) must be paid before I can reschedule an appointment. ***Please be aware the counseling/therapeutic process may involve personal awareness and can be emotionally painful, cause heightened emotions/anxiety, tension or stress. This may lead to some disruption/turmoil in your life as well as your significant others due to the subject matter being disclosed.*** **** I certify I have read and understood the HIPAA client rights/confidentiality guidelines.**

_________________________________ _________________________________

Client Signature Parent's Signature (if client is a minor)