# INTAKE FORM

Dr. Frank E. Allen, LPC
5750 Balcones, Suite 101-B
Austin, Texas 78731

Date _____

**Biographical Information:**

Name _____ Age _____ Date of Birth _____

Address _____ City _____ Zip Code_____

Phone _____ Work Phone _____

Cell Phone _____ Contact Permitted at above numbers? _____

Email Address _____

Occupation _____ Place of Employment _____

Primary Duties _____

_____

_____

**Educational Information**:

| | Where | Dates of Attendance | Major and/or Degree |
|---|---|---|---|
| HighSchool | | | |
| College | | | |
| Graduate School | | | |
| Other | | | |

Who referred you, and what is your relationship to them?

_____

_____

_____

## MARITAL STATUS

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's Name _____ Age _____

Spouse's Education _____

Spouse's Place of Employment _____

Primary Duties _____

Length of Marriage _____ Length of Courtship _____

If Separated, Date of Separation and Explanation _____

_____

_____

_____

_____

_____ Divorced:

Ex-Spouse's Name _____ Age _____

Length of Marriage _____ Length of Separation _____ Date of Divorce_____

Reason for Divorce_____

_____

_____ Previous Marriages:

Date(s): From-To _____ Cause of Divorce: _____

_____

Date(s): From-To _____ Cause of Divorce: _____

_____

_____ Widowed:

Spouse's Name _____

Length of Marriage _____ Date of Death _____ Age at Death _____

Cause of Death _____

## CHILDREN

Name(s) Age School Year Living Arrangement Spouse/Parent

_____

_____

_____

_____

_____

_____

_____

## PHYSICAL/MEDICAL

Do you presently have any pressing physical health problems? If yes, please explain:

_____

_____

Describe any significant health problems you have had in the past three years:

_____

_____

Do you use any medications? Please explain: _____

_____

_____

Do you have any physical symptoms related to your complaining problem? (headaches, nausea, weight loss, sleeplessness etc.) Y/N _____ Please explain: _____

_____

_____

_____

## FAMILY OF ORIGIN

Father _____ Age _____ Mother_____ Age _____

Health Condition _____ Health Condition _____

If deceased, date of death _____ If deceased, date of death _____

Cause _____ Cause _____

Occupation (Current or Previous) Occupation (Current or Previous)

_____ _____

Are your parents: ( ) married ( ) separated ( ) divorced ( ) remarried

If raised in step family, please describe the arrangement: _____

_____

_____

Brothers/Sisters (living and/or deceased) Age Marital Status Children Where Living Occupation

_____

_____

_____

_____

_____

## THERAPY HISTORY

Have you had previous psychotherapy? _____ When? _____

With whom? _____ Where? _____

How would you rate your previous psychotherapy experience?_____

_____

_____

# CLINICAL POLICIES

## LENGTH OF APPOINTMENT

The regular clinical session (a clinical hour) lasts 50 minutes, a half-session lasts 25 minutes, a session and a half lasts an hour and 15 minutes, and a double session lasts 1 hour and 45 minutes. Please be punctual to assure yourself the full time allotted.

## FEES

The fee for a regular clinical session is $200.00. The fee for a half-session is $100.00. The fees for variable sessions are based on the rates above. You are expected to make full payment at the time of the appointment.

## CANCELLATION OF APPOINTMENT

You will be charged for canceled appointments unless notice is received at least twenty-four (24) hours prior to the appointment time so that the time may be scheduled for another client. Late cancellations will be billed as a missed appointment at the rate of $200.00 per hour.

The cancellation policy applies regardless of the reason for cancellation. Please note that our Answering Machine answers 24 hours a day, seven days a week.

## INSURANCE

All fees are due from you at the time of each session. You will need to have the insurance company reimburse you for those sessions. We do not file insurance claims for you, but we will assist you in filing by providing a written statement at your request. No statements will be sent unless requested.

## CONFIDENTIALITY

We would like to reassure you that information presented during therapy is confidential. However, we would like you to know that there are some rare exceptions where ethics and/or Texas state law require confidential information to be shared. These include indications of clear intent to harm yourself or someone else, and indications of child abuse, elder abuse, or abuse of the disabled. In some cases, your file may be subject to a court subpoena. In addition, if you file for insurance reimbursement, insurance companies may require routine information.

## TELEPHONE CALLS

Routine telephone calls for scheduling or a quick question are, of course, part of my service and are not billed. Telephone calls that extend more than ten minutes and are therapeutic in nature will be billed on a prorated basis.

## MISCELLANEOUS

You may terminate the therapeutic relationship at any time you desire without fault.

## CLINICAL POLICIES (cont'd)

LPC Consumer Complaint Hot-Line 1-800-942-5540
Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183

Dr. Frank E. Allen's Credentials:

- B.A. in Psychology from Rice University in 1974
- M.A. in Human Development Counseling from the University of Denver in 1977
- ED.D. in Educational Counseling from the University of Houston in 1979
- Post-Doctoral Fellowship at the Houston Family Institute,1979 - 1980
- LPC - Licensed Professional Counselor

The offices in this building are home to different individuals, each of whom is engaged in his or her own private practice. Please note that each person is an independent practitioner and is not in partnership with or affiliated with other individuals leasing space in this building.

_____

I understand and accept the clinical policies.

_____
Signature

_____
Date