ANDREWS & ASSOCIATES
COUNSELING

## CLIENT INFORMATION

*This is the person who is seeking services. If the client is a minor, please complete for the minor. There is a parent/guardian section below.

Client's Name _____DOB _____ Age_____ SS# _____

Address _____ City _____ State _____ Zip_____

*May we send correspondence to this address?* ☐ *No* ☐ *Yes* **If no, other address* _____

Gender ☐ Female ☐ Male Relationship Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other _____

Work Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Veteran ☐ Active Military/National Guard

Occupation_____ Company/*School (if student*) _____Grade_____

Mobile# _____ May we leave a message? ☐ No ☐ Yes
Mobile Carrier (ex. AT&T, Sprint, Verizon) _____ May we send a text reminder of your appointment? ☐ No ☐ Yes
Home# _____ May we leave a message? ☐ No ☐ Yes
Work# _____ May we leave a message? ☐ No ☐ Yes
Preferred Method of Contact: ☐ Mobile ☐ Home ☐ Work

E-mail address _____May we contact you at this e-mail? ☐ No ☐ Yes
May we send an appointment reminder at this email? ☐ No ☐ Yes

**Others you wish to have access to your appointments and/or billing information. We will leave a message unless instructed otherwise.**

Name _____Relationship _____ Best Phone# _____

*(FOR MINORS)* Does the client live with this person? ☐ No ☐ Yes, 50/50 split custody ☐ Yes/Other _____

## HOW DID YOU HEAR ABOUT US?

☐ Friend/Family member ☐ Google/Internet ☐ Insurance Co/EAP ☐ Physician ☐ School ☐ Church ☐ Other _____

## EMERGENCY CONTACT

Name _____Relationship _____Best Phone# _____

## PRESENTING CONCERN

Please describe your reason for seeking help _____
_____

## MEDICAL/MENTAL HEALTH STATUS AND HISTORY

List any medical or physical problems and date they were diagnosed _____

List any major surgeries _____

List any serious illness or injuries, especially anything involving your head_____

List any food or drug allergies_____

Family history of mental/emotional/behavioral problems? ☐ No ☐ Yes If, yes who?_____ Relationship_____

## PHYSICIAN INFORMATION

Primary Care Physician's name (if applicable) _____Phone # _____

A signed release is required for us to contact your physician.

**OFFICE USE ONLY:**

DX: _____

## PRESCRIPTIONS/OTC DRUGS/SUPPLEMENTS

Are you currently taking prescription medication(s) for mental health care? ☐ No ☐ Yes

Please list **ALL** prescriptions, over the counter drugs (OTC), supplements, and dosage:

| ***Name*** | ***Dosage/Frequency (if applicable)*** | ***When Prescribed? (if applicable)*** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## PARENT/PERSON #2

☐ I am completing this as a parent or guardian of a minor. ☐ I am completing this as person #2 (ex: spouse, partner).

Name _____DOB _____ Age: _____ SS# _____

Address _____ City _____ State _____ Zip _____

Gender ☐ Female ☐ Male Relationship Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other _____

Work Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Veteran ☐ Active Military/National Guard

Occupation/Company _____ School _____ Grade Level _____

Mobile# _____ May we leave a message? ☐ No ☐ Yes
Mobile Carrier (ex. AT&T, Sprint, Verizon) _____ May we send a text reminder of your appointment? ☐ No ☐ Yes
Home# _____ May we leave a message? ☐ No ☐ Yes
Work# _____ May we leave a message? ☐ No ☐ Yes
Preferred Method of Contact: ☐ Mobile ☐ Home ☐ Work

E-mail address _____May we contact you at this e-mail? ☐ No ☐ Yes
May we send an appointment reminder at this email? ☐ No ☐ Yes

## FINANCIAL INFORMATION

☐ I am utilizing my Employee Assistance Benefits.

☐ I am self-pay and have agreed with my therapist the rate of $_____ per session.

☐ I have another arrangement made such as my University/College or Church is paying for my sessions.

☐ I am using my health insurance. Please complete below.

Insured's Name _____Insured's Date of birth _____ Insured's Phone_____

Relationship to Client _____ Insured's Address _____

City _____ State _____ Zip _____ Insurance Company _____

Policy # _____ Group# _____ Insured's SS#_____

## PERMISSION TO BILL INSURANCE

I give permission for Andrews & Associates to bill my insurance and obtain any information that is necessary to process my insurance claims. I understand that A & A must provide a clinical diagnosis to my insurance company and that this information is part of my record with A & A and the insurance company. I further acknowledge that I am financially responsible for all charges not covered by my insurance.

Client/Responsible Party Signature _____ Date _____
*(If client is over the age of 12, client signs here.)*

Parent/Guardian _____ Date _____

Signature #2 (for couples) _____ Date _____

ANDREWS & ASSOCIATES
COUNSELING

## Welcome

Welcome to Andrews & Associates. This agreement contains important information about our professional services and business policies. We provide counseling services to individuals regardless of race, color, creed, handicap, socioeconomic status, and sexual orientation.

## Client Policies (*Please read thoroughly and initial after each item on the line provided. You will have an opportunity to ask questions.)*

1. The client understands that counseling has both benefits and risks. Potential benefits include improved emotional stability, better relationships, resolving internal conflicts, and more effective problem solving. Possible risks may involve increased awareness of distressing emotions (i.e., sadness, anxiety, anger, guilt, loneliness, etc.) relationship changes, and the recall of unpleasant events. (_____)

2. The client agrees to work together with the therapist to identify treatment goals and to follow through on the therapist's referrals and/or recommendations. The client understands that lack of participation and consistent refusal will impair the effectiveness of treatment and may result in the termination and referrals. (_____)

3. The client understands that our office complies with those standards set forth by HIPAA. No information will be shared without your written consent. However, there are exceptions such as suspected abuse, neglect, and if you are a danger to self or others. While these situations are rare, we will take action such as notifying the police, notifying the potential victim(s), seeking hospitalization for the client, contacting family members, or others who can provide protection. All therapists are mandated reporters and must report any form of abuse to DCFS.(_____)

4. The client agrees to pay for services at the time of the session. If utilizing insurance, the client understands that the payment collected is based upon the quote of benefits received from your insurance company's customer service. While we will file claims on your behalf, we may ask for your participation in claims processing should any problems arise. The client understands that any coverage issues are to be addressed by him/her to the insurance company. The client does not hold our office liable for a misquote of benefits from the insurance company. In addition, if the client has not made a payment towards his/her account by the third session, services may be suspended and referrals may be offered. (_____)

5. The client understands that a diagnosis (i.e. depression, anxiety, etc.) must be reported to his or her insurance company for a claim to be processed. (_____)

6. The client understands that a fee will be charged directly to his/her account for any session cancelled less than **24 hours prior to an appointment. Insurance <u>can not</u> be billed for missed appointments.** If the client is more than 15 minutes late, this will also be considered a missed appointment and directly billed to the client. (_____)

7. The client understands that our office cannot be held responsible for providing services in the event of life-threating situations. The client understands to contact 911 or go to his/her local emergency room. (_____)

8. The client agrees not to attend sessions while under the influence of alcohol or other drugs. If the therapist believes that the client is under the influence of alcohol or drugs, the session will be terminated. (_____)

9. The client understands that email or text messaging is not 100% confidential. (_____)

10. The client understands that our office does not accept Facebook friend requests from clients or follow clients on Twitter. (_____)

11. The client agrees to pay $35.00 on returned checks in addition to the original amount. (_____)

12. The client understands that our office does not become involved in any custody, visitation, or legal disputes without therapist's agreement and prepayment made by the client. (_____)

13. (SKIP IF NOT APPLICABLE) The client understands that in divorce situations, our office will only collect payment from the parent who initiated services. We do not offer divided billing services. These type of arrangements are to be worked out between the parents. We also expect that the individual representing a minor has privileges to consent to medical care. We will not be held liable for any misrepresentations. We may ask for a copy of the divorce decree. (_____)

14. The client acknowledges that he/she has read the Kansas Notice of Privacy Policies (HIPAA). (_____)

15. The client understands that any unscheduled phone call between the client and therapist exceeding 10 minutes will result in a fee added to the client's account. The client understands insurance can not be billed for this service. (_____)

16. The client understands that preparation of a report may result in a fee added to the client's account. If a request for medical records by the client or third party is made, there will be a $25.00 charge for any request exceeding one. (_____)

17. The client understands that his/her therapist reserves the right to make final decisions about enforcement of these policies and in making any exceptions. (_____)

18. The client understands that if an outside party requests protected health information, all adults involved in treatment are required to sign a Release of Information. (_____)

**Acknowledgment of Understanding**

I/We have read and understand the Counseling Agreement and Policies. I/We acknowledge that I/We have had the opportunity to discuss this and ask any questions.

_____ _____ _____ _____
Client Signature Date Parent/Guardian Signature Date

_____ _____
Signature #2 (couples) Date

*I, the therapist, have discussed the information above with the client (and/or with his/her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.*

_____ _____ _____ _____
Therapist Printed Name Date Therapist Signature Date

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**CLIENT'S NAME: _____ DATE: _____**

**SYMPTOM CHECKLIST**

Please check the symptoms you have experience in the **last 6 months.**

| SYMPTOM | Never or Rarely | Sometimes | Frequently | SYMPTOM | Never or Rarely | Sometimes | Frequently |
|---|---|---|---|---|---|---|---|
| Feel sad, unhappy | | | | Financial problems | | | |
| Feel hopeless | | | | Legal problems | | | |
| Feel worthless | | | | Problems at work or school | | | |
| Feeling bad about self | | | | Unable to make decisions | | | |
| Worry a lot | | | | Thinking about suicide | | | |
| Feeling alone | | | | Making plans for suicide | | | |
| Seem to be having less fun | | | | Suicidal attempts | | | |
| Less social than usual | | | | Hurting/Scratching/Burning self | | | |
| Irritable, angry | | | | Thoughts about self- harm | | | |
| Uncontrollable temper | | | | Wanting to hurt self | | | |
| Sudden mood changes | | | | Pulling Hair | | | |
| Fidgety, unable to sit still | | | | Panic attacks | | | |
| Daydream too much | | | | Phobias | | | |
| Missing hours or days | | | | Avoiding places/situations | | | |
| Easily distracted | | | | Nightmares | | | |
| Racing thoughts | | | | Flashbacks | | | |
| Having trouble concentrating | | | | Compulsive behaviors | | | |
| Forgetfulness | | | | Alcohol use (see page 2, yes) | | | |
| Tire easily, little energy | | | | Drug use (see page 2, yes) | | | |
| Too much energy | | | | Wanting to hurt others | | | |
| Sleep Problems | | | | Violence towards others | | | |
| Trouble getting to sleep | | | | Obsessive thoughts | | | |
| Increase in appetite | | | | Repetitive Actions | | | |
| Decrease in appetite | | | | Seeing things others don't | | | |
| Binging/overeating | | | | Hearing things other don't | | | |
| Self-induced vomiting | | | | Past or current physical abuse | | | |
| Unexpected weight gain | | | | Past or current sexual abuse or assault | | | |
| Unexpected weight loss | | | | Past or current emotional abuse | | | |
| Tingling or numbness | | | | Excessive guilt | | | |
| Family problems | | | | Health problems | | | |
| Headaches/Stomach aches | | | | Other: _____ | | | |

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**CLIENT'S NAME: _____ DATE: _____**

## SUBSTANCE USE

Please complete this chart based on the substances you use in any amount at all.

| **Substance** | **First Use Age** | **How often?** Weekday | Weekend | Month | **How much?** | **Last use date** |
|---|---|---|---|---|---|---|
| Beer | | | | | | |
| Spirits/Liquor | | | | | | |
| Wine | | | | | | |
| Marijuana | | | | | | |
| Cocaine/Crack | | | | | | |
| Methamphetamine/Crystal Meth | | | | | | |
| Heroin | | | | | | |
| Barbiturates (Downers) | | | | | | |
| PCP, LSD (Hallucinogens) | | | | | | |
| Tobacco (in any form) | | | | | | |
| Other (please list | | | | | | |

**Adults (18 years of age and older) please answer the following questions.**

| | | |
|---|---|---|
| Have you ever felt like you should cut down on your drug or alcohol use? | ○ Yes | ○ No |
| Has a friend or relative expressed concerns about your use? | ○ Yes | ○ No |
| Have you ever felt guilty about your drinking or drug use? | ○ Yes | ○ No |
| Have you ever had to take a drink or use a drug the next day to steady your nerves? | ○ Yes | ○ No |
| Are you a recovering alcoholic or a recovering drug addict? | ○ Yes | ○ No |
| Is there a history or problems with drug or alcohol use in your family? | ○ Yes | ○ No |

**Adolescents (12 years to 17 years of age) please answer the following questions.**

| | | |
|---|---|---|
| Have you ever used alcohol or drugs before or during school? | ○ Yes | ○ No |
| Have you ever missed school because of use or just to use? | ○ Yes | ○ No |
| Have you ever avoided non-users? | ○ Yes | ○ No |
| | ○ | ○ |
| | ○ | ○ |
| | ○ | ○ |