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 ☐ Other 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 send appointment reminders to this e-mail? ☐ 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.

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 _____ 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 send appointment reminders to this e-mail? ☐ No ☐ Yes

FINANCIAL INFORMATION

☐ I am utilizing my Employee Assistance Benefits.

☐ I am self-pay

☐ 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

COUNSELING POLICIES AND INFORMED CONSENT

Welcome to Andrews & Associates Counseling! 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.

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. 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 is informed of risks and understands that email and text messaging are not 100% confidential. (_____)

10. The client understands that our office does not accept social media friend requests or follow client accounts. (____)

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 Practices (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. (_____)

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CLIENT'S NAME: _____ DATE: _____

SYMPTOM CHECKLIST

Please check the symptoms you have experienced 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