# *IMPORTANT INFORMATION*

**Andrea Johnson, M.A., LPC, PLLC**
3740 Colony Dr. Ste. 122
San Antonio, TX 78230
Ph. 210-919-1610
Fax 855-272-3737

## *Welcome to Therapy*

We all experience pain, loss, anger, fear, and heartache in life. It can be intimidating to talk about things you don't even want to think about. Trusting a stranger with your innermost thoughts, fears, and desires can be frightening, but talking about things is often the first step toward change. I believe in building a genuine and collaborative relationship that instills hope and empowers you in this process. I value individual differences and will help you increase your self-awareness and insight to create growth and improve your quality of life. Therapy is most helpful when the foundation is built on trust, clarity, commitment, and understanding. Please keep in mind that therapy is only as effective as you want it to be. A successful treatment outcome depends on the effort you put in. I as your therapist can only help you as much as you are willing to help yourself. If for any reason you feel a lack of improvement in your treatment please be open and honest with me so we can work on a new plan. I'm sure you have many questions and I will do my best to help you understand and feel comfortable as we work together. You will receive forms that need to be filled out prior to our first session so I can understand your need for treatment as well as so you can be inform of policies, legal obligations, and your rights prior to starting our sessions. I look forward to helping you navigate through life's difficulties.

If you need to make an appointment or send me document(s) you may do so by phone, text, email, or fax. Please allow 24 to 48 business hours for a response. All lines of communication are kept safe and confidential. **I am not able to communicate about therapeutic issues except for in sessions**. Excluding making appointments, ***Non-emergent phone calls are billed at $25 per 15-minute increments.***

- Phone/Text: 210-919-1610
- Email: andrea@mhtherapytx.com
- Website: andreajohnsonlpc.com

**Office Location:**
3740 Colony Dr. Ste. 122
San Antonio, TX 78230

**Emergency Situations:**
Crisis/Emergency calls will be charged at $50 per 15 minute increments. If your insurance does not approve this, you are responsible for the charge. **THIS OFFICE DOES NOT HAVE 24/7 PHONE MONITORING. If in crisis, please see below for options.**

There will be times I am not readily available, if this happens and you feel that you are having an emergency situation to include, but not limited to, thoughts of hurting yourself or others please contact 911, go to a local ER, or call a local mental health facility. Some local facilities are listed below. You can also find other resources for help on my website. It is important to have a backup plan when I am not available.

- 911
- National suicide prevention line: 800-273-8255
- Crisis Text Line: Text "HOME" to 741-741
- Laurel Ridge: 210-491-9400
- San Antonio State Hospital: 210-531-7831
- San Antonio Behavioral Health: 210-541-5300

**Cancelation Policy:**
Please keep in mind that if you can't make a session **it is your responsibility to notify me at minimum 24 business hours prior** to your appointment or there will be a **$50 fee.** You may **call, text, or email 24/7**.

*For copies of or more details on the above information, please visit my website and click on the forms tab or ask for a copy at the time of your appointment.*

# *CLIENT PACKET*

**Andrea Johnson, M.A., LPC, PLLC**
3740 Colony Dr. Ste. 122
San Antonio, TX 78230
210-919-1610

**Please keep the first page as it obtains important information.**

**Have the insurance card & ID of the client available to be copied at the time of the appointment.**

**If the client is over the age of 15 they must sign all documents as well.**

# *CLIENT CONTACT & INSURANCE INFORMATION*

**Andrea Johnson, M.A., LPC, PLLC**
3740 Colony Dr. Ste. 122
San Antonio, TX 78230
210-919-1610

## CONTACT INFORMATION

CLIENT NAME: _____ DOB: _____/_____/_____ AGE: _____

SS #: _____-_____-_____ GENDER: _____ RACE/ETHNICITY: _____

PHONE NUMBER: _____ ☐Cell ☐Home ☐Work

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ (PLEASE PRINT CLEARLY)
**(Guardian's email if client is under 18 years old)**

Do you authorize information to be mailed/sent to your ☐HOME ☐EMAIL ☐BOTH ☐NONE

EMERGENCY CONTACT NAME: _____

EMERGENCY PHONE #: _____ RELATIONSHIP TO YOU: _____

## INSURANCE INFORMATION

*PRIMARY INSURANCE COMPANY*: _____ PHONE: _____

ID#: _____ GROUP#: _____ **OR** DoD *benefit* # (Military Only): _____-_____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____/_____/_____ SUBSCRIBER'S SS #: _____-_____-_____

SUBSCRIBER'S EMPLOYER: _____

*SECONDARY INSURANCE COMPANY*: _____ PHONE: _____
***(Required if you have a secondary insurance)***

ID#: _____ GROUP#: _____ **OR** DoD *benefit* # (Military Only): _____-_____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____/_____/_____ SUBSCRIBER'S SS #: _____-_____-_____

SUBSCRIBER'S EMPLOYER: _____

***By signing below, I understand that if I reframe from listing any insurance/medical coverage I may have, I am liable for any outstanding payments owed to the provider. I understand there is no expiration date/timeframe for payments to be collected. I understand that it is my obligation to submit any and all insurance information to the provider and if I fail to do so, the provider is not obligated to submit any past billing to my insurance company and that I am responsible for any payments due.**

## RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY OR INSURANCE

I authorize Andrea Johnson, M.A., LPC, PLLC to disclose case records (diagnosis, case notes, psychological reports, testing results, and/or other requested material) to the above listed payer/insurance company for the purpose of receiving payment. I understand that access to this information will be to determining insurance benefits and/or medical necessity for treatment. I understand that I may revoke this consent at any time by providing written notice. I certify that I have read and agree to these conditions.

**Client's Name (please print):** _____ **DOB:** _____/_____/_____

**Client's Signature:** _____ **Date:** _____/_____/_____

**Guardian's Name (please print):** _____

**Guardian's Signature:** _____ **Date:** _____/_____/_____

# *PHONE, EMAIL & TEXT CONSENT*

**Andrea Johnson, M.A., LPC, PLLC**
**3740 Colony Dr. Ste. 122**
**San Antonio, TX 78230**
**210-919-1610**

HIPAA requires that I keep your Protected Health Information (PHI) private and secure. I find this to be very important for my client's and therefore, I must make you aware of the possibility of leaked information when using emailing, text messaging or leaving a voicemail. While emails and texts are convenient ways to communicate about administrative matters such as *scheduling appointments, receiving an appointment reminder, requesting an invoice, or asking about billing*, I can't promise it to be 100% secure. The following are potential risks you may encounter when using these communication methods.

1. Incorrect delivery of an email or text to a mistyped email address or phone number.
2. Possible 3rd party access to content and contact information by "hackers."
3. Someone checking your electronic means of communication without your consent.

For these reasons ***I ask that you not discuss client information through these means of communication***. An appointment will need to be scheduled to discuss any client issues. These methods of communication will only be used for administrative reasons as listed above.

**PLEASE INITIAL BELOW**:

_____ I **DO** consent to allowing my therapist to contact me via email, or text about administrative matters and I understand the risks that are involved. _____ I **DO NOT** agree with using text or email for administrative matters.

_____ I understand that my therapist may leave me a voicemail regarding administrative matters.

_____ I understand that it is my responsibility to inform my therapist of any phone number or email changes as soon as possible.

*You have the right to revoke this consent at any time by submitting your request in writing.

**Client's Name (please print):** _____ **DOB:** _____/_____/_____

**Client's Signature:** _____ **Date:** _____/_____/_____

**Guardian's Name (please print):** _____

**Guardian's Signature:** _____ **Date:** _____/_____/____

Who will be the main point of contact?

☐ Client ☐ Guardian(s)

**Email Address**: _____

**Phone Number:** _____

# *Credit Card Authorization Form*

**Andrea Johnson, M.A., LPC, PLLC**
**3740 Colony Dr. Ste. 122**
**San Antonio, TX 78230**
**210-919-1610**

CLIENT NAME: _____ DOB: ____/____/____

I hereby grant Andrea Johnson, M.A., LPC, PLLC permission to process credit/debit card charges. Acceptable forms of payment are: check, cash, or credit card. The following terms must be accepted entirely if a credit card will be used for services.

Client's/Guardian **initials** below:

_____ Without my debit/credit card in hand, I authorize Andrea Johnson, M.A., LPC, PLLC to use my debit/credit card number provided below to process fees assigned to the named individual listed above.

_____ I authorize Andrea Johnson, M.A., LPC, PLLC to be compensated for missed appointments of which the client named above did now show up for session or canceled session less than 24 business hours before the time of the appointment. Missed and late canceled appointment fees are billed at $50. **Appointments can be canceled 24/7 by calling, texting, or emailing.**

_____ I authorize Andrea Johnson, M.A., LPC, PLLC to use my credit card for services rendered and then not covered by my insurance provider, such as services applied to deductibles, expired policies, crisis calls/sessions, etc.

_____ *I understand that if I decline to keep a card on file and I owe fees, I must pay them on or before the next scheduled session or services will be terminated and you will be referred to another therapist*.

*I understand that I may revoke this authorization at any time by providing a request in writing.

**By initialing above and signing below, I understand that I am authorizing the use of any credit card I provide to Andrea Johnson, M.A., LPC, PLLC for services, regardless if I list the card below, provide it in person, or over the phone.**

CARDHOLDER'S NAME: _____

CARDHOLDER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TYPE OF CARD: ___VISA ___MASTERCARD ___DISCOVER ___AMERICAN EXPRESSS

CARD NUMBER: _____-_____-_____-_____

EXPERATION DATE: _____ CVV CODE: _____

**CARDHOLDER'S SIGNATURE: _____ DATE:** _____/_____/_____

**Signed by:** ☐ Client ☐ Guardian

# *Financial Policy & Fees for Services*

**Andrea Johnson, M.A., LPC, PLLC**
**3740 Colony Dr. Ste. 122**
**San Antonio, TX 78230**
**210-919-1610**

Andrea Johnson, M.A., LPC, PLLC, is committed to providing caring and professional mental health services to all clients. As part of the delivery of mental health services I have established a financial policy, which explains my payment/fee policies to all consumers. The financial policy is designed to clarify the payment policies as determined by the therapist.

**The person responsible for payment of services is required to sign this form, in order to obtain therapy services. Your insurance policy, if any, is a contract between you and the insurance company; I am not part of the contract with you and your insurance company. Any insurance issues or questions should be directed to your insurance company.**

As a service to you, I will bill insurance companies and other third-party payers, but **I cannot guarantee such benefits or coverage.** In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the person responsible for payment is responsible for payment of these services. **The client or their guardian are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.** *ALL INSURANCE PROTOCOL IS THE CLIENTS/GUARDIANS RESPONSIBILITY TO KNOW, UNDERSTAND, AND FOLLOW. THIS INCLUDES ANY ADJUSTMENTS MADE BY THE INSURANCE PROVIDER THAT MAY DIFFER FROM THE ORIGINAL QUOTE OF BENEFITS. It is best that you contact your insurance company directly to verify benefit coverage. The therapist will not be held liable for any incorrect quote of benefits as providers are not always given accurate information from the insurance company, therefore, it is the clients/guardians responsibility to verify benefits prior to treatment.* Additionally, the Person Responsible for payment (i.e. client, client's guardian, etc.) are responsible for any payments due for services that are not paid for by their insurance policy now or in the future (recoupment) to include but not limited to allowable amounts for services, co-payments, co-insurance, and/or deductibles.

Your insurance company may not pay for services that they consider to be non-efficacious, not medically necessary, and/or an ineligible service (not covered by your policy, the policy has expired, or is not in effect for those receiving services). Regardless of the reason, ***if the insurance company does not pay for services rendered, you are responsible for the balance*** (the amount charged for professional services). The intake session is charged at $200.00. Additional sessions are charge at $90 to $150.00 per session. Sessions are held for 30, 45, or 60 minutes depending on client need as well as insurance coverage. Sessions over 60 minutes are typically not covered by insurance companies.

**The person responsible for payment of services is financially responsible for paying any balance not paid by insurance companies or third-party payers within 30 days.** Payments, co-payments, and deductible amounts are due at the time of service. However, if not paid at the time of session, there is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 30 days of the billing date. Payments not received after 120 days are subject to being sent to collections.

**Insurance deductibles/co-payment/co-insurance amounts are due at the time of services.** Although it is possible that deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider or doctor since January of the current year that were prior to the first session at this office), this amount may be collected until the deductible payment is verified to the therapist by the insurance company or third-party provider and will be refunded if necessary.

The client (guardian of the minor client or person responsible for payments) is required to pay any balance at the time of service. *Unaccompanied minors will be denied nonemergency services* unless charges have been preauthorized to an approved credit card on file or payment arrangements have been made prior to the scheduled appointment.
Payment methods include check, cash, or credit card. The following credit cards are accepted: Discover, Mastercard, or Visa. There is a **$25.00 fee** for declined transactions/returned checks.

***Missed appointments or cancellations*** made less than 24 business hours prior to the appointment are charged at a rate of **$50.00** per missed/canceled appointment. If a client is more than 15 minutes late for their appointment, the appointment will be canceled and you will be charged the late cancelation/missed appointment fee of $50.00. It is at the therapists descretion to discontinue services if a client or client's guardian consistently cancels and/or reschedules their appointments. If this occurs, the client will be provided referrals for a new provider.

***Non-emergent phone calls*** to the therapist are **$25.00** per 15-minute increments (10 minutes = $25.00, 17 minutes = $50.00, etc.) except when making an appointment.

***Emergency/crisis calls/visits*** (unscheduled) are charged at **$50.00** per 15-minute increments (10 minutes = $50.00, 36 minutes = 100.00, etc.). If your insurance company does not allow for this service, you are responsible for the billed amount. **This office does not have 24/7 phone monitoring. If a crisis occurs outside of business hours and/or the therapist is not available to answer, please call 911.** The therapist will not be held liable for missed crisis calls.

***Additional fees for professional services include the following:***
*Court proceeding* attendance is billable at a starting rate of $200 per hour, to include travel time to and from the office as well as any time spent waiting for appearance. If travel further than a 40-mile radius is required, all travel, accommodation, and food expenses will be paid by the client with a per diem of $200 per day minimum. If an attorney is required for the therapist, all fees will be billed to the client. Regardless of who requests the therapist's appearance (i.e. client, lawyer, subpoena, etc.), by signing below, you agree to pay the fees listed above.

*Records copy request* paper or electronic (if approved) are subject to an administrative fee of $40.00 per 15-page increments (i.e. 1 to 15 pages is $40), including partial increments (i.e., 16 pages is $80.00, etc.) A written request must be submitted at least 72 (business) hours prior to obtaining copies of records.

*Written requests* to include request to have paperwork filled out, request to have a letter written, request for a case report, etc. will be quoted on a case-by-case basis with a starting point of $75 up to $1500 per request, per client depending on the request and time involved to complete your request. *Not all requests will be approved*.

*Telephone/Telehealth* appointments are sometimes denied by certain insurance companies due to being considered a "non-covered service." It is recommended that you verify your benefits before requesting a telehealth appointment as you will be responsible for the fee for service if not covered by insurance. Telephone/health appointments will be billed at the same rate as an in-office visit (please see rates above). *Not all requests will be approved*. It is at the discretion of the therapist whether or not telephone/health services will be provided.

*Private pay* sessions are accepted and will be charged at $200.00 for the intake session and $90 to $150 per each following session. Sessions are held for 30, 45, or 60 minutes.

**Clients using a credit card, your card will remain on file and will be automatically charged for co-payments, missed/late/canceled appointments (unless canceled 24 business hours before your appointment), non-emergent calls, crisis calls, etc. as discussed above. If you decline to leave a method of payment on file with the office, all fees are due on or before the next scheduled session, if further sessions are not scheduled, fees are due within 30 days of date acquired. *If fees incurred are not paid, treatment will be terminated and balance may be sent to collections*.**

By signing below, I have read, understand, and agree with the provisions of the Financial Policy & Fees for Services discussed above.

**Client's Name (please print):** _____ **DOB:** _____/_____/_____

**Client's Signature:** _____ **Date:** _____/_____/_____

**Guardian's Name (please print):** _____

**Guardian's Signature:** _____ **Date:** _____/_____/_____

# *Informed Consent*

## *(Privacy Policies & Your Rights)*

**Andrea Johnson, M.A., LPC, PLLC**
**3740 Colony Dr. Ste. 122**
**San Antonio, TX 78230**
**210-919-1610**

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.**

**Legal Duties**
State and Federal laws require that providers keep your medical records private. Such laws require that providers inform you of the privacy of information policies, your rights, and our duties. The therapist is required to abide by these policies until replaced or revised. The therapist has the right to revise this privacy policies for all medical records, including records kept before policy changes were made.

The contents of material disclosed to the therapist in an evaluation, intake, or therapy session are covered by the law as private health information (PHI). Providers respect the privacy of the information you provide and will abide by ethical and legal requirements of confidentiality and privacy of records.

**Use of Information**
Information about you may be used by the personnel associated with this office for diagnosis, treatment planning, treatment, and continuity of care. The therapist may disclose it to health care providers who provide you with treatment, such as doctors, nurses, other mental health professionals, and/or their business associates affiliated with the office for reasons such as billing or audits.

Both verbal information and written records about a client cannot be shared with another party without written consent from the client or the client's legal guardian (if the client is a minor) or personal representative. It is policy not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

**Duty to Warn and Protect**
When a client discloses intentions or a plan to harm another person or persons, the provider is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the provider is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Public Safety**
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

**Abuse**
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the provider is required to report this information to the appropriate social service (CPS) and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, the therapist may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

**Prenatal Exposure to Controlled Substances**
Providers are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Professional Misconduct**
Professional misconduct by a health care provider must be reported by other health care provider(s). In cases in which a professional or legal disciplinary meeting is being held regarding the health care provider's actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial or Administrative Proceedings**
Providers are required to release records of clients when a court order has been placed.

**Minors/Guardianship**
All guardians of a minor child (until 18 years old) have the right to be informed of the child's therapy. If the minor's guardians are divorced or separated, both parents still have the right to know about their child's treatment regardless of what one parent says about another, unless legal documentation stating otherwise can be provided.

While the guardian(s) has the right to be informed about a minor child's treatment, the child still has the right to privacy. Therefore, the information shared with a guardian is limited. However, a guardian will be informed if the minor child has disclosed thoughts or actions of harming their self or others.

**Other Provisions**
When payment for services are the responsibility of the client, or a person who has agreed to pay for the client(s) services, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time frame, and the name of the office/provider or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding the client. Information that may be requested includes type of services, dates/times of services, diagnosis, therapy notes, treatment plan, description of impairment, progress of therapy, and/or summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports may be dictated/typed within the office or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the office or mental health professional must contact the client for purposes such as appointment cancellations, reminders, or to give/receive other information, efforts are made to preserve confidentiality.

***As a policy, I do not engage in any social media with clients and any requests to communicate through these mediums will be deleted to maintain confidentiality.***

A client's file will be closed after 180 days of no treatment (sessions/appointment), with or without notice to the client.

**Complaints:**
*If you have any complaints or questions regarding these procedures, please contact the provider. The therapist will get back to you within 72 hours. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Texas State Board of Examiners of Professional Counselors Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only.*

**Your Rights**
You have the right to request to receive your medical records. The procedure for obtaining a copy of your medical information is as follows. Requests must be made at least 72 business hours in advance. If your request is denied, you will receive a written or electronic explanation of the denial. Records for non-emancipated minors must be requested by their legal guardian(s). The charge for records request can be found on page 7. All requests need to be picked up in

person. Medical records may not be disclosed if there is concern it may negatively affect the client. This includes records of a minor child.

You have the right to cancel a release of information by providing a written notice.

You have the right to restrict which information might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them.

You have the right to request that information about yourself be communicated by other means or to another location. This request must be made in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. The request must be made in writing.

*If you desire a written copy of this notice you may obtain it by requesting one from the therapist or printing it off of the website: andreajohnsonlpc.com*

By signing below, I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications discussed above.

**Client's Name (please print): _____ DOB: _____/_____/_____**

**Client's Signature: _____ Date: _____/_____/_____**

**Guardian's Name (please print): _____**

**Guardian's Signature: _____Date: _____/_____/_____**

# *CLIENT HISTORICAL INFORMATION*

**Andrea Johnson, M.A., LPC, PLLC**
**3740 Colony Dr. Ste. 122**
**San Antonio, TX 78230**
**210-919-1610**

**Client Name:**_____ **Date of Birth:** _____/_____/_____

**Reason for seeking therapy:**

☐Anxiety ☐Coping ☐Behavioral problems ☐Self-harm ☐Depression ☐Fear/Phobias
☐Self-Esteem Issues ☐Addiction Issues ☐Anger management ☐Relationship Issues
☐Other: Please specify: _____

**Relationship Status:**

☐Single ☐In a Relationship ☐Married ☐Divorced ☐Separated ☐Widowed

**Living Arrangements:**

Who do you live with? _____
*Minor children & Adolescents:*
Parent's divorced or separated? ☐Yes ☐No
Any current custody issues? ☐Yes ☐No
Who has primary custody? _____

**Family Interactions:**

☐Absence of sensitivity or understanding of each other
☐Understanding of each other
☐Polite w/o warmth or affection
☐Usually warm and affectionate
☐Difficulty expressing feelings
☐Constant arguing
☐Estranged/distant with my family
☐Other: _____

Please explain any relevant family problems?

_____

_____

**Developmental History:**

Adopted ☐Yes ☐No

Any history of abuse? ☐Yes ☐No

If Yes, which type(s)?

☐Sexual ☐Victim ☐Perpetrator
☐Physical ☐Victim ☐Perpetrator
☐Emotional ☐Victim ☐Perpetrator
☐Neglect ☐Victim ☐Perpetrator

Was the abuse reported? ☐Yes ☐No

History of being bullied? ☐Yes ☐No

Are there any other circumstances that may have affected your development/mental health? ☐Yes ☐No

If yes to any of the above, please briefly explain:

_____

_____

**Education:**

Highest/current grade level: _____ Currently enrolled in High School? ☐Yes ☐No

If yes, Name of school: _____

College degree or currently in college? ☐Yes ☐No

If yes, Major: _____ Name of School: _____

Special circumstances (i.e., learning disabilities, gifted): _____

Other training or educational information: _____

**Employment:**

Currently employed? ☐Yes ☐No

If yes, where and for how long? _____ Years _____ Months _____

**Military Service:**

Are or were you ever in the military? ☐Yes ☐No

Currently active duty? ☐Yes ☐No

**Social Relationships:**

Check how you generally get along with other people: (check all that apply)

☐Affectionate ☐Aggressive ☐Avoidant ☐Fight/argue often ☐Follower

☐Friendly ☐Leader ☐Outgoing ☐Shy/withdrawn ☐Submissive

☐Other (specify): _____

**Sexual Identification:**

☐I'd rather not say

☐Heterosexual ☐Homosexual ☐Bisexual ☐Sexual Identity Issues ☐Other: _____

**Cultural/Ethnic:**

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ☐Yes ☐No

If Yes, describe: _____

**Spiritual/Religious:**

How important to you are spiritual matters? ☐Not at all ☐A little ☐Moderately ☐A lot

Are you affiliated with a spiritual or religious group? ☐Yes ☐No

**Substance Use History/Treatment:**

Do you have any history of substance use (this includes tobacco use)? ☐Yes ☐No Age/Date started: _____

If yes, is it currently an issue? ☐Yes ☐No Age/Date last used: _____

List substances utilized currently or in the past, treatment received, and outcome:

Substance(s): _____

Treatment: _____

Outcome: _____

**Psychiatric History:**

Have you or a relative ever experienced, been diagnosed with, or been treated for:

***Please indicate with letters: **S**=self, **M**=mother, **F**=father, **B**=brother, **SI**=sister, **GM**=grandmother, **GF**=grandfather, **R**=other relative*

| | | |
|---|---|---|
| [ ]Aggression/homicidal ideation | [ ] Suicidal ideation/attempts | [ ] Bipolar disorder |
| [ ] Childhood developmental problem(s) | [ ] Psychosis | [ ] Depressive disorder |
| [ ] IDD (intellectual disability disorder) | [ ] Delusions/Hallucinations | [ ] Spectrum disorder |
| [ ] ADD/ADHD | [ ] Traumatic Experiences/PTSD | [ ] Mood disorder |
| [ ] Personality Disorder traits | [ ] Schizophrenia | [ ] Anxiety disorder |
| [ ] Eating Disorder | [ ] Disruptive/defiant | [ ] Other_____ |

**Past Psychiatric Treatment:**

Prior inpatient hospitalization(s): ☐Yes ☐No
Prior/current outpatient treatment: ☐Yes ☐No
If yes, please explain when, were, and for how long:

_____
_____
_____

**Medication:**

Are you currently on any medications? ☐Yes ☐No
If yes, please list all medications you are taking for mental/physical/medical healthcare:

| | |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

**Health/Medical Issues:**

Do you have any current physical/medical health issues? ☐Yes ☐No

If yes, please briefly explain: _____

**Legal:**

Any history of legal issues? ☐Yes ☐No

Currently on probation? ☐Yes ☐No

Charges pending? ☐Yes ☐No

If yes, for what? _____

**Leisure/Recreational:**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Do any of these activities help you to cope? ☐Yes ☐No

**Current Strengths:** What are you good at, what areas of life do you excel at, etc.?

1._____ 3._____ 5._____

2._____ 4._____ 6._____

**Current Deficits/Problems:** What areas of life may be affecting you, what are you missing in life, etc.?

1._____ 3._____ 5._____

2._____ 4._____ 6._____

**What intervention(s) if any have you tried in the past (i.e. therapy, hospitalization, self-help books/videos, etc.)?**

_____

_____

**Any other factors you would like to add that may be relevant to know for your treatment?**

_____

_____

**How were you referred to Andrea Johnson, LPC, PLLC?**

☐ Self-Search ☐ A Friend/Family Member ☐ Other: _____

☐ Hospital: _____ ☐ Doctor: _____

**Client's Name (please print):** _____ **DOB:** _____/_____/_____

**Client's Signature:** _____ **Date:** _____/_____/_____

**Guardian's Name (please print):** _____

**Guardian's Signature:** _____ **Date:** _____/_____/_____

**Filled out by**: ☐client ☐guardian(s) ☐both (we filled it out together)