



Andrea Morganstein, LPC, LLC

203 W Chestnut Street, Ste 202
West Chester, PA 19380-2517

Phone: (610)314-0799
Fax: 610-601-5999
www.amcounseling.net

Welcome!

You have scheduled your first appointment with me and I would like to explain a little bit about what to expect.

1. First, this will be an opportunity for me to introduce myself to you and for you to start to get a sense of whether you think we will work well together. Having a good client-therapist match is important and if today, or at any point down the road, you think it would be a good idea to try working with someone else, I will do everything that I can (if you wish) to find someone else for you to work with. No therapist is a good match for all people and I don't take a request for a change personally.
2. Second, there will be some general paperwork for me to go over with you and have you sign; HIPAA and such. Yay paperwork...I'm sure you love it as much as I do but it is still important stuff.
3. Third, we will then have an opportunity for me to start to get to know you. I will be asking questions about what is going on now as well as a bunch of general screening questions about some things in the past that may have had an effect on you. A top priority will, of course, be a bunch of questions about safety, but the answers to all of these questions are important.

Because we only have 75-90 minutes during the initial session to cover a lot of territory, and I would like to spend as much time as I can, focusing on what brought you in to our office to start counseling, I have created a few forms for you to fill out so that I can look over it quickly and then ask you for more details about items that are significant for you. A lot of these questions can be tough ones for a person to answer, if it is about something that is affecting them. So...

- I will explain this in more detail in our session but know **that the information that you share in this form is confidential**. It will be kept in your individual file that is stored within a locked drawer in the office and/or in an encrypted computer file. The **main exceptions** to confidentiality is when I am worried that someone has been, is getting, or at risk of getting seriously hurt or when you have given me written permission to share information with another party. (Other exceptions are detailed further in my Communications Policy and HIPAA Policy.)
- If there is something that you aren't ready to share at this time, please leave it blank and you can share that information with me if or when you are ready to at a later point.
- If there is something that you write down because you feel it is important for me to know but you also aren't ready to talk it about during this first session, please make a note in the margin about your wishes and I will respect them. The only time that I would still try to get some more information would be, again, when there are safety issues. Otherwise, I will follow up during the session to ask a few more details so that I can understand a bit more what that issue means to you.

If you should have any questions, I am happy to answer them in the session. I look forward to meeting with you!

Sincerely,

Andrea R. Morganstein, MS, LPC
Licensed Professional Counselor (# PC006679)

Crisis Resources



Help is just a call or text away!

IF IT IS A MEDICAL EMERGENCY CALL

911

If you need to talk to someone right away (free)

Call or Text

988

www.988lifeline.org

Just want to talk? Call the Chester County Warmline

866-846-2722 during the hours of operation: **Monday through Friday from 8:00 AM to 10:00 PM and weekends 10:00 AM to 10:00 PM.**

Chester County's Valley Creek Warmline is operated by Certified Peer Specialists, who are trained and certified individuals in recovery from mental health challenges.

Established clients who can wait at least 24 hours and still be safe:

You can call my office **phone number, 610-314-0799**, to leave me a confidential voicemail message, send me a **non-confidential text, 484-314-0799**, or **use your confidential account on the Spruce phone app.**

I monitor my phone during business hours and do my best to call back **within 1-2 business days.**

If I am taking time off, you will have an option to contact covering colleague of mine who can return your call to provide a brief phone consultation.

Andrea Morganstein, LPC, LLC
203 W Chestnut Street, Suite 202
West Chester, PA 19380
Phone: 610-314-0799

Create Confidential Communication Account on Spruce App:
<https://spruce.care/amcounseling>



Intake Paperwork Summary

for

ANDREA MORGANSTEIN^{LPC} LLC

APPOINTMENTS

Typical Session: 45 mins.

Longer Session: 53-60 mins, can increase cost.

Crisis Session: 60-90 mins, can increase cost.

Cancellations: 24-Hr Notice Required

(See my exceptions and fees in "Financial Policy")

CONFIDENTIALITY

My office is a safe space where you can trust that I won't share your private information with anyone unless I have your permission...with a few, very specific exceptions such as for:

- Billing purposes.
- Anonymous consultation with other professionals as needed to enhance quality of services to the client.
- Immediate risk of harm to self or others.
- Any information regarding suspected child abuse of any minor, in the past or currently.
- Suspected elder abuse or abuse of an adult with limited mental or physical capacity.
- Certain adolescent sexual relationships that are considered illegal.
- Court order.
- Other governmental reporting (rare) that the law may require.

(See details in "Client Information and Consent to Treatment/Evaluation" and "HIPAA Privacy Notice")

AVAILABLE CONTACT METHODS

100 % Confidential

Phone Call 610-314-0799

Fax 610-601-5999

Client Portal (must have an account)

(Regular texting and email is optional, with consent, but I can't guarantee confidentiality on the internet.)

I will try my best to respond within
24- hours, on business days.

RUNNING INTO EACH OTHER OUT IN THE WORLD

Basically, I follow your lead. Depending on the situation I will either pretend that I don't see you or offer a casual, "stranger level" smile unless you acknowledge or approach me. *(See details in the "Communications Policy")*

** EMERGENCIES **

Medical/Immediate Safety Emergencies:

Call 911

Need to Talk Right Away:

Call 988

If You Can Wait up to 24+ Hours:

Try using my contact information above
(See details in "Crisis Resources")

PAYMENT & FEES

Expected on date of service.

Cash, check, or credit, HSA.

24-Hour Cancellation Policy or there will be a progressive fee.

You have a right to a cost of treatment estimate.
(See details in the "Financial Policy")

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Master Signature Page

Consent to Treatment (revision July 1, 2026)

Your signature below indicates that you have been provided with a copy of the Consent to Treatment document (Rev. 7/1/2026) and agree to abide by its terms during our professional relationship.

If you wish to revoke this signature at any time, you are welcome to do so.

CLIENT (if client is 14 or older) Signature Print Name **Date**

PARENT/GUARDIAN (if client is a minor) Print Name **Date**

Financial Policy (revision July 1, 2026)

Your signature below indicates that you have been provided with a copy of the Financial Policy (Rev. 7/1/2026), which includes the late cancellation policy, and agree to abide by its guidelines. I understand that Andrea Morganstein, LPC, LLC does NOT have a relationship with my insurance provider and is considered "out of network." Further, I understand that I am financially responsible for all balances and fees and will pay them directly to Andrea Morganstein, LPC, LLC at time of service.

If you wish to revoke this signature at any time, you are welcome to do so.

RESPONSIBLE PARTY Signature Print Name **Date**

Communication Policy (Revision 11/12/19)

Initial Your Preferences and then Sign Below

	Texts	Initial Your Preference	Emails	Initial Your Preference	
Secure	via Spruce App		via Hushmail		Secure
Insecure	"normal" texting		"normal" email		Insecure
Not at All	no texts		no email		Not at All

This consent will terminate at the end of treatment, unless you otherwise indicate on the line below:

I (we) understand that my consent to participating in email or texting exchanges can be terminated either by Andrea Morganstein or by me (us) at any time.

I (we) have been provided with the Communications Policy (Rev. 11/12/10), feel that that Andrea Morganstein has informed me (us) to the best of her abilities, and I (we) consent to the above indicated forms of communication.

I (we) further understand that if we choose to text or email Andrea directly, that the confidentiality of the information that we send can't be guaranteed and we are waiving our right to exclusively using confidential means of communication about our private health information.

CLIENT (if client is 14 or older) Signature

 Print Name

Date

PARENT/GUARDIAN (if client is a minor)

 Print Name

Date

HIPAA Privacy Notice (Revision 6/8/2017)

As required by the federal Health Insurance Portability & Accountability Act, I have received a copy of the Andrea Morganstein, LPC, LLC's HIPAA Privacy Notice Form (Rev. 6/8/2017).

CLIENT (if client is 14 or older) Signature

 Print Name

Date

PARENT/GUARDIAN (if client is a minor)

 Print Name

Date

Today's Date: _____

Client Information

Last Name		First Name		MI	Birthday		Age
Street Address				City		State	Zip
Mark Best # To Call	Type	Phone #	Msg OK?	Email Address			
	Cell		<input type="checkbox"/>				
	Home		<input type="checkbox"/>	Y N	Do you want to receive occasional emails about the practice, groups, seminars, workshops, & satisfaction surveys. (I will <u>NEVER</u> release email address to 3rd parties)		
	Work		<input type="checkbox"/>				
If client is a child, please list any parent or guardian that has at least legal custody of this child.							
Name:				Name:			
Relationship:				Relationship:			
Occupation:				Occupation:			
Address:				Address:			
Mark Best # To Call	Type	Phone #	Msg OK?	Mark Best # To Call	Type	Phone #	Msg OK?
	Cell		<input type="checkbox"/>		Cell		<input type="checkbox"/>
	Home		<input type="checkbox"/>		Home		<input type="checkbox"/>
	Work		<input type="checkbox"/>		Work		<input type="checkbox"/>
Emergency Contact Info							
Name:				Mark Best # To Call	Type	Phone #	Msg OK?
Relationship:					Cell		<input type="checkbox"/>
Address:					Home		<input type="checkbox"/>
					Work		<input type="checkbox"/>

Who referred you or how did you learn about this practice?

Client Information (continued)

CLIENT'S PRIMARY DOCTOR / MEDICAL INFORMATION / PRIMARY DOCTOR RELEASE

Practice and/or Doctor & Phone Number:	When was the you/your child's most recent physical exam?	
Please list any allergies that pose a risk for you or your child:		

Because mental health is part of the health care system and one of the roles of your primary care physician is to assist in coordinating your overall care, it is often helpful to inform your primary care physician that you/your child have started therapy with me. Would you like to consent to me sending them a courtesy letter that contains a brief mention of the "symptoms" (to use the medical term) that brought you here today? (This is completely optional.)

Pleaes initial one option below...

_____ **Yes**, I would like you to notify my/my child's primary care physician, as detailed above. _____ **No**

FINANCIAL INFORMATION / RELEASE

(1) If client is a minor and parents aren't married, who is legally responsible for paying this medical expense?

Please provide name and relationship below...

Name: _____ **Relationship:** _____

(2) If client is an adult, is there another family member or person in your life that you want to give me permission to speak to regarding payment and billing issues?

Pleaes initial one option below...

_____ **Yes**, I would like you to contact: _____ **No**

If the answer to either question (1) or question (2) above whose contact information is not already listed on the first page of this form, please provide this information below.

Name:	Mark Best # To Call	Type	Phone #	Msg OK?
Relationship:		Cell		<input type="checkbox"/>
Address:		Home		<input type="checkbox"/>
		Work		<input type="checkbox"/>

I attest that the information I have reported in this form is accurate to the best of my knowledge. Further, my signature below finalizes my above initialled preferences regarding the release of information to my primary care physician and regarding my financial obligations to this practice.

Print Name
Signature
Date

ANDREA MORGANSTEIN, LPC, LLC
 203 W. Chestnut Street, Ste 202
 West Chester, PA 19380
 610-314-0799

Client Legal Name: _____

Date of Assessment: _____

Identity

What name would you like me to call you? _____

What pronouns would you like me to use if I refer to you in the third person?
 he/him/his she/her/hers Other: _____

How do you identify yourself? (circle all that apply)
 Straight Lesbian Gay Bi/Pan Transgender Cisgender Questioning Other _____

Health

Sleep Quality

Y N	Problems with quality of sleep?	Y N	Often tired during the day?
	FALLING ASLEEP MULTIPLE INTERRUPTIONS EARLY WAKE	Y N	Snoring?
Y N	Nightmares?	Y N	Unusal leg discomfort/movements
Y N	Fall asleep during day when you want to stay awake?		

Other

Y N	Any chronic/on-going medical conditions?	Y N	Any history of head trauma/concussions?
-------	--	-------	---

If 'yes' please explain...

Please List All Medications and Who Prescribes Them

Exercise

How do you exercise your body?

Therapist notes :

Client Legal Name: _____

Date of Assessment: _____

Diet/Nutrition											
Describe a typical day of eating:											
Y		N	Do you have problems with your appetite?	Y		N	Do you have stomach or bowel trouble?				
Y		N	Do you have food allergies/sensitivities?	Y		N	Are you a picky eater?				
Y		N	Do you ever diet?	Y		N	Ever felt like you want to throw-up after eating?				
Y		N	Restrict yourself from eating certain foods or follow any rules about your eating?	Y		N	Ever actually done anything to compensate for the food you have eaten? (laxitives, throw-up)				
Y		N	Ever felt a loss of control over eating?	Y		N	Is your body the way you would like it to be?				
Safety											
Your Safety											
Y		N	In past 3 months, have you hurt yourself purposely but not because you were trying to die?								
Y		N	In your lifetime, have you hurt yourself purposely but not because you were trying to die?								
Y		N	Have you ever thought about not wanting to be alive any more?								
Y		N	Have you ever thought about ending your life?								
Have you ever experienced:											
Y		N	Physical Abuse	Y		N	Sexual Abuse	Y		N	Emotional Abuse
Y		N	Domestic Violence	Y		N	Ever Been Threatened?	Y		N	Ever Been Bullied?
Any other experience of trauma including medical trauma?											
Anger Control											
Y		N	Have you ever thought about physically hurting someone.								
Y		N	Have you ever threatened to physically hurt someone?								
Y		N	Have you ever hit or otherwise hurt someone or an animal?								
Y		N	Have you ever been arrested for physically hurting someone or an animal?								
Misc											
Y		N	Is your home a safe place?	Y		N	Is your neighborhood a safe place?				
Y		N	Is your job/school a safe place	Y		N	Do you experience harassment?				
Y		N	Are there any firearms in your home?								
Y		N	If "yes," are the firearms locked securely and ammunition stored separately?								
Y		N	Do you have or have you ever had a fascination with fire/history of setting fires?								
Therapist notes :											

Client Legal Name: _____

Date of Assessment: _____

Substance Use											
Caffeine											
Describe your daily caffeine consumption:											
Nicotine											
Y		N	Do you use nicotine (cigarettes/cigars/chewing tobacco/patch/gum)								
If yes...details: (type of nicotine, how much, how long have you been using it?)											
Marijuana											
Y		N	Do you use marijuana?								
If yes...details: (How often do you use marijuana per day or per week? How much with each use? Age when first used it?)											
Alcohol											
Age of first drink?											
Average # alcoholic drinks on typical drinking day?											
How often do you drink 6/+ alcoholic drinks on one occasion?											
Most recent alcoholic drink?											
Other Drugs											
Y		N	Current experimentation with recreational drugs?								
Y		N	Current over use of prescription meds or taking prescription meds not prescribed to you?								
Y		N	Past experimentation with recreational drugs or prescription medication?								
All Substances											
Y		N	Have people ever said they were concerned about your drinking or other drug use?								
Y		N	Have you ever had guilt/bad feelings about your drinking or other drug use?								
Y		N	Have you ever used alcohol or other drugs first thing in the morning just to steady your nerves?								
Has your drinking or other drug use ever caused clinically significant impairment or distress in the following areas:											
Y		N	Personal Relationships	Y		N	Work	Y		N	Health (blackouts, substance-related medical problems)
Y		N	Legal (DUI's, arrests)	Y		N	Financial				
Comments/concerns about any of your substance use?											
Past Substance Use Treatment											
Type of Treatment			Provider			Meds		Outcome			
<i>Therapist notes :</i>											

Client Legal Name: _____

Date of Assessment: _____

Substance Use (continued)

Family Substance Use History

Y | N | Family History of Substance Abuse/Dependence/Addiction?

If yes...who?

Use of AI (for example, ChatGBT, Gemini, Claude, Grok)

Y | N | Have you in the past or do you currently sometimes use AI to address mental health or social issues?

Y | N | Have you in the past or do you currently sometimes use AI when you are lonely or as "someone to talk to?"

AI can be a helpful thing but it can also pose some risks and challenges. The reality is that all of us use AI in one way or another. What do you think it would be helpful for me to know about your AI use?

Is there anything else about you that I should know but you aren't quite ready to talk about yet?

Multisymptom Checklist

Please Circle Anything That You Feel Are Issues for You

- | | | | |
|-----------------|----------------------|----------------------|---|
| aggression | energy | marriage | sexual identity |
| ambition | family arguments | memory | shyness |
| anger | fears | nervousness | social challenges |
| anxiety | finances | news/current events | social media |
| appetite | friendships | over-dependency | stealing/lying |
| avoidance | gender identity | over-sensitive | stomach trouble |
| career choices | grooming/self-care | panic attacks | temper tantrums |
| children | harrassment | parenting | tiredness |
| concentration | headaches | physical complaints | under-activity |
| controlling | hearing voices | relaxation | excessively defiant/argumentative |
| cruelty | impulsive | running away | unusual habits or rules compelled to follow |
| demanding | inferiority feelings | school problems | over-activity/hyperactive |
| depression | jealousy/resentment | self-control | difficulty telling imagination from what's real |
| destructive | legal matters | self-critical/guilty | feeling less powerful than others |
| easily upset | lonliness | separation/divorce | feeling more powerful than others |
| eating problems | my thoughts | sex problems | worry you are being watched |
| education | making decisions | stress | work |

Therapist notes :

Client Name: _____

Date: _____

Intake Evaluation - Client Self-Report

Please rate from 0 to 10 for each description within the last month/lifetime.

	Rate on a scale of 0-10 (0 = never and 10 = constantly) Please circle		Notes
	An Issue in the Past Month	Worst Month in my Lifetime	
Excessive Guilt Feelings	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Feelings of Worthlessness	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Low Energy Level	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Difficulty Concentrating	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Feeling Alone	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Feel Like a Burden	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Hopeless	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Withdrawing from your Support System	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Dramatic Mood Changes	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Reckless/Dangers Behavior	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Physically Agitated/Can't Sit Still	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Chronic Pain	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Feeling Trapped	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Writing About Death	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Thoughts About Hurting Yourself	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Giving Away Possessions	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Have You Been Saying, "Goodbye" to People?	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Working to Get Your Financial Affairs in Order	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	
Thoughts About Hurting Someone Else	0-1-2-3-4-5-6-7-8-9-10	0-1-2-3-4-5-6-7-8-9-10	

Reviewed by: _____

Andrea R. Morganstein, MS, LPC