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!

Today is your first appointment with me and I would like to explain a little bit about what to expect today.

1. First, this is an opportunity for me to introduce myself to you and your child as well as a chance 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 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 60-75 minutes 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 this form 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 your child. A lot of these questions can be tough ones for a person to answer, especially if it is something that is affecting someone they love. 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 child's individual file that is stored within a locked drawer in the office. 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 or your child are ready to at a later point.
- If there is something that is important for me to know but you or your child aren't ready to talk about it 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 and your child.

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
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

Rev. 10/15/19

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		☐		
	Home		☐	Y | N	Do you want to receive occassional emails about the practice, groups, seminars, workshops, & satisfaction surveys. (I will NEVER release email address to 3rd parties)
	Work		☐		

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		☐		Cell		☐
	Home		☐		Home		☐
	Work		☐		Work		☐

Emergency Contact Info

Name:	Mark Best # To Call	Type	Phone #	Msg OK?
Relationship:		Cell		☐
Address:		Home		☐
		Work		☐

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		☐
Address:		Home		☐
		Work		☐

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

Andrea Morganstein, LPC, LLC

PARENT COMPLETED
BACKGROUND SCREENING

Child

Client Legal Name: _____ Date of Assessment:_____

Person(s) completing this form :_____ Your relationship to child:_____

Identity
What name does your child prefer to be called? _____
What pronouns do they prefer people to use when referred to in the third person? he/him/his she/her/hers Other: _____
The Good Stuff!
Please list this child's strengths and things that people enjoy about him/her.
Current Challenging Issues
In a sentence or two, what are the difficulties that this child is experiencing:
Please describe how the issues you mentioned above developed over time/when they started to become problematic?
Therapist notes:

Client Legal Name: _____ Date of Assessment:_____

What have you tried on your own to try to help your child with these issues? What has worked and what hasn't? (Note: The sign of a "good parent" is not one that gets things right all the time but one that tries to solve problems...keeping the solutions that work, scrapping those that don't, and looks for information from outside sources when they are stumped. For a therapist to better understand what is going on, sometimes, what hasn't worked can provide just as much information as what has worked.)

Have you tried to get outside help for these challenges before? Yes____ No____ (If yes, list what kind of help & when/where it took place.)	**Current & Past Mental Health Medication:**

Family History

Please circle any emotional difficulties experienced by this child's immediate or extended family and note which family

excessive saddnes/depression	difficulty controling temper	suicide attempts/completions
excessive worry/panic/fear	difficulty staying focused/organized/managing time	seeing or hearing things that aren't there/delusional

Other issuea not listed above?

What important things (positive or negative) have happened in this child life or the family's life in the last year?

Education

School/District	**Current/Highest Grade**	**Teacher**

Learning Disabilities/IEP/504? **Suspensions/Expulsions?**

Therapist notes:

Client Legal Name: _____ Date of Assessment:_____

Medical Issues

Current Medical Issues & Significant Medical History (include chronic illnesses and any major medical problems the child may have experienced in the past):	**Current Medications:**

Sleep Quality		**Details:**
Y | N	Problems with quality of sleep? FALLING ASLEEP | MULTIPLE INTERRUPTIONS | EARLY WAKE	
Y | N	Often tired during the day?	
Y | N	Snoring?	
Y | N	Unusal leg discomfort or movements during the night	
Y | N	Falling asleep during the daytime when you want to stay awake?	

Diet/Nutrition

Y | N	Eat three healthy meals/day?	Y | N	Limit junk food?	If they complain about their body, please give details below about what they say/do in this regard.
Y | N	Make themself throw-up after a meal?	Y | N	Binge eat?	
Y | N	Take laxitives when not constipated?	Y | N	Complain about their body?	

Details:

Safety Issues

Suicide/Self Harm

Past 3 months	**Lifetime**	Have you been worried that your child has…
Y | N	Y | N	...been thinking of ending their life?
Y | N	Y | N	…engaging in risky or dangerous behavior?

Non-Suicidal Self-Injury History

Y | N	Has your child hurt themself purposely, in any way, without intent to die?

Trauma History

Y | N	Physical Abuse	Y | N	Domestic Violence
Y | N	Sexual Abuse	Y | N	Ever Threatened?
Y | N	Emotional Abuse	Y | N	Other Trauma?

Danger to Others

Y | N	Have they ever talked about physically hurting someone.
Y | N	Have they ever threatened to physically hurt someone?
Y | N	Have they ever hit or otherwise hurt someone or an animal?
Y | N	Have they ever been arrested for physically hurting someone or an animal?
Y | N	Do they "play" with fire in a way that feels risky?

Details for anything marked "Yes":

Therapist notes:

Client Legal Name: _____ Date of Assessment:_____

Substance Use	
Do you suspect your child uses or has experimented with any form of:	
Y | N	nicotine: cigarettes/cigars/chewing tobacco/patch/gum?
Y | N	alcohol?
Y | N	recreational drugs?
Y | N	misuse/abuse of prescription medications (theirs or someone else's)?

If yes…provide details *What forms of nicoteine/alcohol/recreational drugs/prescription medication? Amount & Frequency? By mouth/injection/other? First/last date of use & frequency?*

Has their drinking or other drug use ever caused problems in the following areas:

Y | N	Friendships	Y | N	School	Y | N	Health (blackouts, substance-related medical problems)
Y | N	Legal (arrests)	Y | N	High risk behavior		

Past Substance Use Treatment

Tx Dates	Provider	Meds	Outcome

Family Substance Use History

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

If yes…who and what/which substance(s)?

Extra Space/Other Pertinent Family Issues

Use the space below to add more details, mention something that is important for me to know that wasn't already covered by the questions in this form, or any family concerns that you don't feel comfortable mentioning in front of your child today but would be helpful to me to know. (Some of these might be: drug/alcohol use in the home; domestic violence; significant physical or mental health issues of another family member; history of trauma; financial problems; incarceration; marital conflict; death.)

Therapist notes:

Client Legal Name: _____ Date of Assessment:_____

Multisymptom Checklist
Please Circle Anything That You Feel Are Issues for Your Child

aggression	education	nervousness	separation/divorce
anger	energy	news/current events	stress
anxiety	family arguments	social media	shyness
appetite	fears	sexual identity	social challenges
avoidance	finances	memory	stealing/lying
body image	friendships	over-dependency	stomach trouble
children	gender identity	over-sensitive	temper tantrums
concentration	grooming	panic attacks	tiredness
controlling	harrassment	phone/electronics use	under-activity
cruelty	headaches	physical complaints	excessively defiant/arguementative
demanding	hearing voices	relaxation	unusual habits or rules they seem to need to follow
depression	impulsive	running away	over-activity/hyperactive
destructive	inferiority feelings	school problems	difficulty telling imagination from what's real
divorce stress	jealousy/resentment	self-control	feeling less powerful than others
easily upset	lonliness	self-critical/guilty	feeling more powerful than others
eating problems	making decisions	self-esteem	worry they are being "watched"

Therapist notes:

Today's Date: _____

Developmental History

Name of child: _____ Date of Birth: _____

Informant(s): _____ Relationship: _____

Pregnancy Information (if known)				
Was child adopted?	**Y**	**N**	Age of adoption: _____	Length of pregnancy: _____ mos
Mother's health during pregnancy: ☐ Good ☐ Fair ☐ Poor				
Any illness/complications during pregnancy?			**Y**	**N**
Any maternal substance use (prescription medication, recreational drugs, alcohol) before or during pregnancy?			**Y**	**N**
Were there complications with labor?			**Y**	**N**
Were there complications with delivery?			**Y**	**N**
Were there health concerns after the birth?			**Y**	**N**
Early Development				
Delays or difficulties in motor skill development (sitting up, standing, walking, running)			**Y**	**N**
Delays or difficulties with language?			**Y**	**N**
Toilet training difficulties/bedwetting?			**Y**	**N**
Unusual childhood illnesses?			**Y**	**N**
Were there health concerns after the birth?			**Y**	**N**
General Medical History				
Has your child had any head injuries or concussions during their lifetime?			**Y**	**N**
Has your child had or do they currently have any major medical issues or medical hospitalizations?			**Y**	**N**
Please use this space to add details for any difficulties during pregnancy, early development or general medical history issues mentioned above.				

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Caretakers		
Over the child's life who have been her/his primary caretakers?		
Has there been any difficulties with the people who have cared for this child?	**Y**	**N**
Has there been any long separation from the primary caregiver?	**Y**	**N**
Please add details in this space.		

Social History		
*Circle all that describe your child's temperament as an **<u>infant and toddler</u>**.* *Add other descriptions as needed.* Shy — Slow to Warm Up Then Confident — Confident — "Into Everything" Easily Frustrated — Often Fussy — Calm — Happy *Other descriptions…?*		
How did your child do with being able to separate from you as a toddler and preschooler (compared to other children around the same age)?		
Does your child have friends to do activities and fun things with?	**Y**	**N**
Does your child have close friends that are particularly special to them?	**Y**	**N**
Does your child make direct eye contact when socializing/speaking with others?	**Y**	**N**
Please list early social or behavioral strengths or challenges:		

School History			
Would you describe your child's academic performance in school as (circle one): **Below Average** **Average** **Above Average**			
What is/are their best subject(s):			
What is/are their worst subject(s):			
Any grades repeated?	**Y**	**N**	If so, which grade(s):
Has your child changed schools besides the typical changes from elementary school to middle/junior high school, to high school? If so, when & why:	**Y**	**N**	
Please describe things that are going well in school and things that have been a problem in school:			

Firearms Safety		
Are there firearms in any home that your child resides in or is cared for in?	**Y**	**N**
If "yes," are the firearms locked securely and ammunition stored separately?	**Y**	**N**

_____ _____

Reviewed by Andrea R. Morganstein, MS, LPC Date