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

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")

Parent or guardian to complete the next 7 pages:

- Master Signature Page (2 pages)
- Client Information (2 pages)
- Developmental History (3 pages)

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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

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.				

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

Youth to complete the next 6 pages:

- Client Completed Background Screening (4 pages)

- Intake Evaluation – Client Self-Report Youth (2 pages)

Andrea Morganstein, LPC, LLC **CLIENT COMPLETED** **Adult/Teen**

BACKGROUND SCREENING

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 their 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

Therapist notes :

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/arguementative
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 (Youth)

	Worst I've Felt in the **Past Month**					How I Felt in my **Worst Month Ever**				
Guilty about Stuff	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Nobody Cares	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Don't Feel Like Doing Anything	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Have a Hard Time Concentrating	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Feeling Alone	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Make My Family's Life Hard	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Things Will Never Get Better	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Want to Talk or Be With People Less Than I Used To	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
My Mood Can Change Really Fast	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Do Dangerous Things or Take Chances Where I or Someone Else Could Get Hurt	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Feel Jumpy and/or Can't Sit Still	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Have Aches and Pains	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time

Client Name: _____ Date:_____

	Worst I've Felt in the **Past Month**					How I Felt in my **Worst Month Ever**				
Feeling Trapped	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Writing About Death	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Thoughts About Hurting Yourself	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Giving My Stuff Away	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Have Been Saying, "Goodbye" to People Because They Might Never See Me Again	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
Thoughts About Hurting Someone Else	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
The Grown-Ups in my Home Fight a Lot	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time
I Worry About How Much People in my House Drink Alcohol or Use Drugs	Never	A Little	Sometimes	Often	All the Time	Never	A Little	Sometimes	Often	All the Time

If this month isn't your worst month ever, about how long ago/when was your worst month ever? _____

Reviewed by: _____
Andrea R. Morganstein, MS, LPC