Amy E. Brown, MS, CADC, LPC, CCTP
610.416.0793
Amyebrown.lpc@gmail.com
www.amyebrown.com

New Client Information

Date:
Date of evaluation:
Name:
Gender/preferred pronouns:
DOB/age:
Address:
Cell:
Email:

If under 18, please list your parent(s) name(s) and phone number(s):

Emergency Contact:

If I need to contact you to change or confirm an appointment, may I do so via email?
Via text? Voicemail?

How did you learn about my practice?

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Adult Client Therapy Intake

Please type your information or print neatly; add extra pages as needed

Date:
Date of evaluation:
Name:
DOB/age:

What do you hope to get out of therapy?

Counseling History:

Have you ever been in any type of counseling?

Dates	Provider/location	Reason	Outpatient/inpatient

Substance Use History:

Please include every substance you've **ever** tried (even once)-including nicotine and marijuana

Substance	Age of first use	Initial pattern	Recent pattern	Date of last use	Consequences
EX: Alcohol	age 16	2-3 beers/weekends	4-6 beers/daily	May 2025	Blackouts, DUI

Family/Social History:

- Are you adopted?
- Where were you born and raised?

- Who was in your home when you were growing up?
- Was there much conflict/fighting/tension in your home growing up?
- Do any blood relatives have mental health and/or substance use issues?
- Were you raised in a particular religion? Do you practice a religion now?
- How are your relationships with family members now?
- Have you been married or in long-term relationships? If so, please provide the dates those marriages/partnerships began and ended
- Where and with whom do you currently live?
- Gender/ages of children or stepchildren:
- Who can you talk to if you're upset about something?
- What do you do to manage stress?

Educational/Military History **Name of school, year graduated, and degree/ license earned**

- High school:
- College:
- Post-college education:
- If you are a veteran, please provide years of service, which branch, and type of discharge. Please also note if you saw combat or were stationed in a war zone.

Employment History (Please account for the last five years) **Name of employer, dates, position, reason for leaving**

- Current employer:
- Previous employers:

Legal History:

- Have you ever been arrested? If so, please provide details:
- Do you have a pending court date?
- Are you currently on probation or parole? If so, please provide details and contact information for your probation officer:

Medical History:

Please list any current medical problems:

Current Medications:

Name, dose, frequency, reason, and type of prescriber (i.e.: psychiatrist, PCP, etc.)

1.

2.

3.

4.

Mental Health History:

If you have any past/current mental health diagnoses, please provide the year of initial diagnosis and any current symptoms.

1.

2.

3.

- How is your sleep? Appetite? General energy level?
- Have you ever considered or attempted suicide? If so, please provide details.
- Have any of your family members attempted or completed suicide? If so, please provide details.
- Have you ever considered or attempted to seriously harm someone else? If so, please provide details.
- Did/do you ever do anything to deliberately harm yourself? If so, please provide details.
- Did/do you ever hear or see things that other people don't? If so, please provide details.
- Did/do you struggle with disordered eating and/or purging? If so, please provide details.
- Please describe your mood and stress level over the past few months:
- Please mention any past/current mental health issues not covered above:

Anything you'd like to add?

Please **scan** all completed forms to me at 24-hours before our appointment: amyebrown.lpc@gmail.com

Thank you!

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Informed Consent, Telehealth, and Fee Agreement

Psychotherapy Services

Psychotherapy is a collaborative process that might involve discussing personal, emotional, or psychological concerns. The goals, methods, and duration of treatment might change over time. Therapy might involve emotional discomfort and no specific outcomes are guaranteed.

Telehealth Services

Services might be provided via a secure, HIPAA-compliant telehealth platform. Telehealth might not be appropriate for all situations. Technical difficulties might occur. Clients are responsible for ensuring privacy. Telehealth is not appropriate for emergencies.

Electronic Communication

Electronic communication is used for scheduling, billing, and sharing forms. It is not appropriate for emergencies. Responses might take up to one to two business days. Electronic communication carries privacy risks and might become part of the clinical record.

Confidentiality

Information shared in therapy is confidential with legal exceptions including court orders, risk of harm to self or others, abuse or neglect.

Fee Agreement

Payment is due at the time of service unless otherwise arranged. I agree to be financially responsible for all fees associated with services provided, including copayments, deductibles, late cancellation or missed appointment fees. Unpaid balances might result in suspension of services or referral to collections as permitted by law.

Acknowledgment and Consent

☐ I have read and understand the information above
☐ I consent to psychotherapy services
☐ I consent to telehealth services
☐ I consent to electronic communication as described
☐ I agree to the fee agreement and payment policies

_____
Printed name

_____
Signature Date

_____
Witness printed name

_____
Witness signature Date

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NOTICE OF PRIVACY PRACTICES (HIPAA)

Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how your protected health information (PHI) may be used and disclosed, and how you can access this information. Please review it carefully.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

- Amy E. Brown, MS, LPC, CADC, CCTP may use or disclose your PHI for treatment, payment, and health care operations with your consent.
- Protected Health Information (PHI): Information in your health record that could identify you.
- Treatment: Providing, coordinating, or managing your health care.
- Payment: Activities required to obtain reimbursement for services.
- Health Care Operations: Administrative and operational activities of the practice.
- Use: Sharing or analyzing PHI within the practice.
- Disclosure: Releasing PHI to parties outside the practice.

Uses and Disclosures Requiring Authorization

- Uses or disclosures of PHI outside of treatment, payment, or health care operations require your written authorization.
- You may revoke an authorization at any time in writing.
- Revocation does not apply to actions already taken in reliance on your authorization.

Uses and Disclosures Without Consent or Authorization

- Child abuse reporting as required by law.
- Adult or domestic abuse reporting when permitted or required by law.
- Health oversight activities.
- Judicial or administrative proceedings.
- Serious threats to health or safety.
- Workers' compensation claims.
- Other legal requirements.

Client Rights

- Request restrictions.

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- Request confidential communications.
- Access records.
- Request amendments.
- Receive an accounting of disclosures.
- Receive a paper copy of this notice.
- Restrict disclosure to health plans when eligible.
- Receive breach notifications.

Provider Responsibilities

- Maintain the privacy of your PHI.
- Provide this notice of legal duties and privacy practices.
- Follow the terms of this notice currently in effect.

Complaints

- You may contact Amy E. Brown directly.
- You may file a complaint with the U.S. Department of Health and Human Services.
- You will not be penalized for filing a complaint.

Effective Date

This Notice of Privacy Practices is effective April 14, 2003, and was last revised June 18, 2026.

ACKNOWLEDGMENT OF RECEIPT

My signature below acknowledges that I have received or been offered a copy of this Notice of Privacy Practices.

Printed Name: _____

Signature: _____

Date: _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Michigan Alcohol Screening Test (MAST)

This test is nationally recognized by alcoholism and drug dependence professionals. You may substitute the words "drug use" in place of "drinking".

1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)
Circle Answer: YES NO

2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?
Circle Answer: YES NO

3. Does any near relative or close friend ever worry or complain about your drinking?
Circle Answer: YES NO

4. Can you stop drinking without difficulty after one or two drinks?
Circle Answer: YES NO

5. Do you ever feel guilty about your drinking?
Circle Answer: YES NO

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
Circle Answer: YES NO

7. Have you ever gotten into physical fights when drinking?
Circle Answer: YES NO

8. Has drinking ever created problems between you and a near relative or close friend?
Circle Answer: YES NO

9. Has any family member or close friend gone to anyone for help about your drinking?
Circle Answer: YES NO

10. Have you ever lost friends because of your drinking?
Circle Answer: YES NO

11. Have you ever gotten into trouble at work because of drinking?
Circle Answer: YES NO

12. Have you ever lost a job because of drinking?
Circle Answer: YES NO

13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
Circle Answer: YES NO

14. Do you drink before noon fairly often?
Circle Answer: YES NO

15. Have you ever been told you have liver trouble such as cirrhosis?
Circle Answer: YES NO

16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?
Circle Answer: YES NO

17. Have you ever gone to anyone for help about your drinking?
Circle Answer: YES NO

18. Have you ever been hospitalized because of drinking?
Circle Answer: YES NO

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
Circle Answer: YES NO

20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?
Circle Answer: YES NO

21. Have you been arrested more than once for driving under the influence of alcohol?
Circle Answer: YES NO

22. Have you ever been arrested, even for a few hours because of other behavior while drinking? (If Yes, how many times _____)
Circle Answer: YES NO

SCORING

Please score one point if you answered the following:
1. No
2. Yes
3. Yes
4. No
5. Yes
6. Yes
7 through 22: Yes

Add up the scores and compare to the following score card:
0 - 2 No apparent problem
3 - 5 Early or middle problem drinker
6 or more Problem drinker

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐