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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Adolescent Client Therapy Intake

Please type or print neatly -add additional pages as needed

Date:
Date of appointment:
Name:
DOB/age:
Identified gender/preferred pronouns:

What do you hope to work on in therapy?
Please list any previous counseling experiences:

Medical history

Do you have any food or drug allergies?

Have you had any significant injuries, surgeries, illnesses?

Do you have chronic pain or chronic illnesses?

Please list all current medications:

Developmental history

Did your birth mother experience any problems while pregnant with you or during/after delivery?

Did you achieve major milestones on time (walking, talking, potty training, etc.)?

Did you receive any early intervention therapies (speech, physical, occupational)?

Family background

Where were you born and raised?
Who was in your home growing up?
Are you adopted? If so, please describe what you know about your birth parent(s)
Were you raised in any particular religion/are you practicing now?
Were any of your parents or grandparents born outside of the US?
Where and with whom do you currently live?
What is the cultural and ethnic background of your family?
Have any of your blood relatives attempted or completed suicide?
Do any of your blood relatives have a history of mental health/ substance use issues?

Parents/stepparents

Name/gender	Age/occupation	Quality of relationship

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Siblings

Name/gender	Age/grade or job	Quality of relationship

Education
Highest grade completed and usual grades:
Are/were you involved with band, sports, or other activities at school?
Do/did you get into trouble at school for behavioral or attendance issues?
Do/did you have an IEP or 504 plans?
Do you have a learning difference or ADHD?
What do you like best about school? Least?

Employment
Do you have a job/volunteer position?
How long have you worked there?
How many hours do you work each week?
Please briefly describe your job responsibilities:

Other stuff:
What are your interests?
How do you relax?
How do you manage stress?
Do you have any concerns about your alcohol or drug use?
Do you feel safe at home?
Do you feel as though you have enough friends?
Who can you talk to when you're stressed?
Do you have any problematic relationships?
Are your friends or family supportive of therapy?

Last one!
Anything you'd like to add?

Please email all completed forms at least 24-hours before our appointment:amyebrown.lpc@gmail.com.
Thanks so much for your time!

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**
☐	☐	☐	☐

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

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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: _____

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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