Andrea M. Carroll, LMSW, ACSW, C-ASWCM
734.649-3065 ▪ 1945 Pauline Blvd., Suite 15C, Ann Arbor, MI 48103

ANDREA CARROLL COUNSELING CONSENT FOR THERAPY

Welcome to my practice. I am pleased to have the opportunity to work with you. This document contains important information about my professional services and procedures. Please read it carefully and discuss any questions you have with me. When you sign this document, it will represent your informed consent for psychotherapy services.

Consent to Treatment: I understand that the services I and/or my dependent(s) will receive are based on currently accepted practices in the field of mental health. Psychotherapy has both benefits and risks: while it is empirically demonstrated to have beneficial effects on emotions, behaviors and relationships, at times it can also arouse distressing thoughts, feelings and behaviors. There are no guarantees as to the results of treatment or of any procedures. It is important to let me know of any concerns you have about your response to our sessions.

Professional Fees and Insurance Coverage: My fee is $125 for a 45-50 minute therapy session. Your health insurance may cover my services (with conditions regarding number of sessions, fee limits, co-pays and deductibles). If I am a participating provider for your plan I will accept their assigned fee and I will bill them electronically. Your co-pay will be due at each session by either check or cash. If insurance does not cover our work or if I am a non-participating provider for your insurance, payment in full is expected at each session unless otherwise arranged. The returned check fee is $30.

Cancellations: I understand that the full fee is charged for appointments missed and for appointments cancelled less than 24 hours in advance. Insurance will not cover missed appointments.

Availability: I routinely check my voicemail and will return your call within 24 hours. Phone calls lasting more than 5 minutes will be billed at the agreed-upon hourly rate. In case of emergency, contact UM Psychiatric Emergency Services at 734-996-4747, go to the nearest hospital emergency room or call 911.

INFORMED CONSENTS:

My signature below shows that I understand the information provided in this document and that I consent to treatment. It also serves as acknowledgement that you have received a copy of the HIPAA Notice.

_____
Printed Name

_____ _____
Signature Date

PAYMENT AGREEMENT:

I authorize the release of any protected health information necessary to process insurance claims for payment. I hereby authorize payment of insurance benefits to be made directly to Andrea Carroll, LMSW. I understand that I am financially responsible to Andrea Carroll, LMSW for services not covered or payable by my insurance carrier.

_____ _____
Signature Date

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ANDREA CARROLL COUNSELING INTAKE FORM

Please fill out this form and bring it with you to your first session. Information you provide is protected and confidential.

Name: (Last, First, MI) _____

Address: (Number and Street, Apt. Number) _____

(City, State, Zip Code) _____

Home Phone: _____ May I leave a message? ☐ Yes ☐ No

Cell Phone: _____ May I leave a message? ☐ Yes ☐ No

E-Mail: _____

Birth Date: (Month, Day, Year) _____ Age: _____ Gender: ☐ Male ☐ Female

Emergency Contact Name: _____ Phone: _____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner Name _____

List any Children and their ages _____

Who referred you? _____

What would you like to accomplish from therapy? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, counseling)? ☐ Yes ☐ No

If yes, list therapist name(s) and approximate dates of service: _____

Please list any prescription medications you are currently taking (name, dose, purpose) _____

Please list any psychiatric medications you have been prescribed in the past. Please list all, including dosages, dates of usage, purpose and general response:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Please rate your current health: ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing: _____

_____

Did you ever, or do you now have any thoughts/behaviors of harming yourself or others? ☐ Yes ☐ No

If yes, please specify: _____

_____

Do you have any history of/or current physical/sexual abuse? ☐ Yes ☐ No

If yes, please specify: _____

_____

Are you currently experiencing fatigue/tiredness? ☐ Yes ☐ No

If yes, please describe your sleep pattern and any problems: _____

_____

Have you experienced recent weight loss or gain? ☐ Yes ☐ No

If yes, please describe how much and over what period of time: _____

_____

Please list frequency and types of physical activities in which you participate: _____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for approximately how long? _____ If yes, what coping strategies are you using?

_____

_____

Are you currently experiencing anxiety, panic attacks or any phobias? ☐ Yes ☐ No

If yes, when did you begin experiencing this? _____ If yes, what coping strategies are you using?

_____

_____

Are you currently experiencing chronic pain? ☐ Yes ☐ No If yes, for approximately how long? _____

If yes, please describe: _____

_____

Do you currently drink alcoholic beverages? ☐ Yes ☐ No If yes, please describe your usage: _____

_____

Do you currently use recreational drugs? ☐ Yes ☐ No If yes, please describe your usage: _____

Are you currently experiencing any life changes or stressful events? ☐ Yes ☐ No If yes, please describe:

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, sister, etc.)

	Please Circle	List Family Member		Please Circle	List Family Member
Alcohol, Substance Abuse	Yes No		Domestic Violence	Yes No	
Anxiety	Yes No		Eating Disorders	Yes No	
Bipolar Disorder	Yes No		Obsessive Compulsive Behavior	Yes No	
Dementia	Yes No		Schizophrenia	Yes No	
Depression	Yes No		Suicide Attempts	Yes No	

ADDITIONAL INFORMATION

What is the highest level of education you achieved? _____

What was your focus of any education after high school? _____

Are you: ☐ Employed ☐ Unemployed ☐ Retired If retired, when and from where? _____

Please describe the work you do/did and if your current situation is stressful or enjoyable: _____

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No If yes, please describe: _____

Please describe your strengths: _____

Please describe your weaknesses: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	