

**Wellspring Counseling**  
**Merry Anderson, MA, LPC**

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New Client Questionnaire

Please be advised that mental health records constitute privileged information that is protected by the law of the State of Texas, and they may contain information that is protected under Federal Confidentiality Regulations. By answering these questions you will assist your counselor in appropriately assessing your particular needs.

**General Information**

Date: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Best Phone Contact (circle type: H, W, C ) \_\_\_\_\_

Contact Email (Optional): \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Ethnicity:  Caucasian  African-American  Hispanic  Asian  Native American  Other

Marital Status:  Single (Never Married)  Married  Engaged  Divorced  Separated  Widowed

Names and ages of spouse/children \_\_\_\_\_

Highest grade completed \_\_\_\_\_ Type of degree \_\_\_\_\_

How were you referred to me? \_\_\_\_\_

If applicable, what church do you currently attend? \_\_\_\_\_

**Presenting Problem**

Why are you seeking counseling at this time? \_\_\_\_\_

\_\_\_\_\_

Have you attended counseling before? If so, briefly describe your previous experience: \_\_\_\_\_

\_\_\_\_\_

Please indicate any medication(s) you are currently taking and for what illness(es): \_\_\_\_\_

\_\_\_\_\_

In a few words, describe your current spiritual life: \_\_\_\_\_

\_\_\_\_\_

What else would you like me to know? \_\_\_\_\_

\_\_\_\_\_

*The information I have provided above is current and accurate to the best of my knowledge.*

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

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Counseling Issues Check List

Listed below are various issues and concerns people often come to counseling for. Please check off any that apply to you in your current situation.

I come seeking:

- Individual counseling
- Couples counseling
- Both

What motivated me to come to counseling:

- |  |   |
|--|---|
| <input type="checkbox"/> Marital difficulties          | <input type="checkbox"/> Unemployment   |
| <input type="checkbox"/> Fear of divorce or separation | <input type="checkbox"/> Career/vocation change                                   |
| <input type="checkbox"/> Divorcing or divorced         | <input type="checkbox"/> Job dissatisfaction                                      |
| <input type="checkbox"/> Non-marital couple struggles  | <input type="checkbox"/> Financial struggles                                      |
| <input type="checkbox"/> Non-marital break-up          |   |
| <input type="checkbox"/> Family Relationship(s)        | <input type="checkbox"/> Loss through death                                       |
| <input type="checkbox"/> Codependency                  | <input type="checkbox"/> Loss through major life change(s)                        |
| <input type="checkbox"/> Boundaries                    | <input type="checkbox"/> Other losses:_____                                       |
| <input type="checkbox"/> Anger Issues                  | <input type="checkbox"/> Physical health-related issues                           |
| <input type="checkbox"/> General relational struggles  |   |
| <input type="checkbox"/> Family of origin issues       | <input type="checkbox"/> Emotional Abuse  |
| <input type="checkbox"/> Alcohol Addiction             | <input type="checkbox"/> Physical Abuse   |
| <input type="checkbox"/> Substance Abuse:_____         | <input type="checkbox"/> Sexual Abuse   |
| <input type="checkbox"/> Other addiction: _____        | <input type="checkbox"/> Spiritual Abuse  |
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Post-Traumatic Stress (PTSD)                             |
| ○ Panic Attacks  | <input type="checkbox"/> EMDR   |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Spiritual Growth & Guidance                              |
| ○ Mild   |   |
| ○ Moderate   | <input type="checkbox"/> Others encouraged me to come                             |
| ○ Severe   | <input type="checkbox"/> Spouse/partner threatens to leave unless I come          |
| <input type="checkbox"/> Stress/Overwhelmed            | <input type="checkbox"/> Court-ordered  |
| <input type="checkbox"/> Bipolar Disorder              |   |
| <input type="checkbox"/> Schizophrenia                 | <input type="checkbox"/> I'm not sure, I knew I just need to talk to someone safe |
| <input type="checkbox"/> Personality Disorder:_____    |   |
| <input type="checkbox"/> Other Mental Illness:_____    | <input type="checkbox"/> _____  |

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Office Policies & Informed Consent

Welcome to my office! Choosing to engage in counseling is an important decision. This handout will assist you in making an informed decision concerning my services. Please feel free to ask questions about my office policies or any other concern you may have about my practice at any time.

**Counseling Services:** Counseling is a process of discovery, learning, healing and growth done in the context of a therapeutic and professional relationship. I utilize various counseling techniques and approaches with my clients to provide what is most needed and what is most effective for each individual client. I embrace a Christian perspective to life and, when desired, will gladly provide spiritual guidance and support along with psychological treatment. I can help you determine a pace that will be most beneficial in your situation. Most clients find that weekly or bi-monthly attendance yield the best results.

**Fees:** Counseling fees are based on a rate of \$120 per 50-minute session. If wishing to utilize insurance, a receipt for self-filing will be furnished. A sliding scale, based on household income and family size, is also made available for those in financial need. If wishing to apply, complete the sliding scale handout included in this packet.

**Payment:** Fees for counseling are due at each visit. Payments can be made by cash or check (credit cards not available at this time.) Make checks payable to Merry Anderson.

**Cancellations:** Missed appointments or cancellations made with less than 24 hours advance notice of a session are subject to a full session fee. This charge is waived in case of illness if a client calls prior to the session. Repeated missed appointments may indicate a lack of readiness or commitment to the counseling process and may result in termination of services.

**\*\*\* I initial that I understand the 24 hour cancellation policy:\_\_\_\_\_**

**Emergencies:** If you have an emergency after hours or require immediate attention when I am not available, please call your doctor or the 24-hour Crisis Hotline (472-4357). You may also call 911 or go to your nearest emergency room if you are in danger of hurting yourself. Attempts to harm yourself may endanger the therapeutic relationship. In such a case, I may refer you to another qualified counselor.

**Legal Fees:** Any fees related to legal actions that require me to reproduce records or participate in depositions or court appearances will be the undersigned's responsibility. Legal fees will be assessed at \$110 per hour.

*I have read, understood, and agree to the information above about therapy services, fees, confidentiality, consultation, emergencies, billing procedures, appointments, and cancellations.*

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

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Confidentiality & Privacy Notice

*This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

I will use the information about your health, which I get from you or from others mainly to provide you with treatment, to arrange payment for services, and for some other business activities, which are called, in the law, health care operations.

Disclosure (send, share, release) of any of your information for any other purposes will be discussed with you and you will be asked to sign an Authorization form to allow this. I will, of course, keep your mental health information private but there are times when the laws of the State of Texas require me to use or share it.

1. If I have cause to believe that a child or elderly person has been, or may be abused or neglected.
2. If you are involved in a court proceeding which involves a court order requiring information about your diagnosis and treatment.
3. If it appears that you pose a serious threat to yourself or someone else, I may disclose relevant health information to medical or law enforcement personnel.

**Your Rights Regarding Your Health Information**

1. **Right to Request Confidential Communication.** You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. I will try my best to do as you ask.
1. **Right to Request Restrictions.** You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
2. **Right to Access to Inspect and Copy.** You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you a reasonable fee for this. I will respond to requests in a timely manner, without delay for legal review, in less than 15 days if submitted in writing. I may deny access to any portion of a record (in accordance with the Texas Health & Safety Code 611.0045 (b)) if I determine that release of that portion would be harmful to a client's physical, mental, or emotional health.
3. **Right to Amend.** If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information, although I am not required to agree to the amendment. You have to make this request in writing and tell me the reasons you want to make the changes.
4. **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you reasonable fees if you request more than one accounting in any 12-month period.

**Complaints:** I am a Licensed Professional Counselor licensed by The Texas State Board of Examiners of Professional Counselors. You have the right to contact the state board with complaints about the professional conduct of any counselor at Complaints Management and and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369 or at 1-800-942-5540.

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Signature of Client

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Sliding Scale Application

**Note: Application for the sliding scale is optional. If you are not interested in the sliding scale you are not required to complete this form.**

The sliding scale is available to those with demonstrated financial need. To apply for the sliding scale, please complete the information below. If your financial situation changes at a later time, your fee should also be adjusted accordingly. The sliding scale is unavailable for anyone utilizing health insurance for counseling. Self-employed people should use their prior year's income to apply.

**Financial Information**

Employment Income (gross)                      \$ \_\_\_\_\_                       monthly                       yearly

Your Spouse or Live-in Partner's  
Income (gross)                                      \$ \_\_\_\_\_                       monthly                       yearly

Other assessable household income  
(SSI, unemploymt, etc.)                          \$ \_\_\_\_\_                       monthly                       yearly

**Total Gross (Before Taxes) Income**       \$ \_\_\_\_\_                       monthly                       yearly

Total Savings & Investments                      \$ \_\_\_\_\_

Household size income is supporting: \_\_\_\_\_

Additional Information you would like to provide: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*The information I have provided above is current and accurate to the best of my knowledge.*

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Client's Signature

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Date