Christine Lister, LMFT#50744 330 E. Lambert Rd. #225 Brea, CA 92821
714.906.1689 cell 714.553.6833 fax ListerCounseling.com Christine@ListerCounseling.com

Biopsychosocial Information

Please fill out completely. Mark "N/A" for anything that does not apply.

Full Name: _____ Nick Name: _____

Address: _____ City: _____ Zip: _____
Street address

Mobile Phone: _____ Alternate Phone: _____
Providing cell number grants permission to leave voice mail and/or text messages related to your appointments

Email: _____
Providing email acknowledges risks to confidentiality inherent with electronic communication

Emergency Contact: _____ Relationship: _____ Phone: _____
Providing an emergency contact waives confidentiality in the event of an emergency

Preferred Method of Contact (select all that apply): _____Text _____Email _____Phone call

Date of birth: ____/____/____ Age: _____ Referred by: _____

Gender: _____ Ethnicity: _____ Sexual Orientation: _____

Education Level/Degree Earned: _____

Occupation: _____ How long: _____ Rate Satisfaction (1-low;10-high) _____

Relationship Status: _____ How long: _____ Rate Satisfaction (1-low:10-high) _____
*(**M**arried, **Div**orced, **W**idowed, **S**ingle-never married, **2nd +** marriage, **C**oupled not living together, **L**iving w/ Significant Other)*

Children with Ages: _____

Active/past military service (branch of service/time): _____

Present Issue(s) including onset: _____

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Significant Deaths/Losses (include miscarriages, abortions, divorce, job loss, financial hardship):_____

_____

_____

Spiritual/Religious Orientation:_____ Rate importance (1-least; 10-greatest):_____

Current Living Situation (include type of housing and all who live with you):_____

_____

_____

Number and gender of siblings:_____

Where are you in the line up (oldest, youngest, middle):_____

Socio-Cultural/Family of Origin (FOO) History (include where you grew up, who raised you, discipline methods, family rules/norms, conflicts, mental illness or addictions):_____

_____

_____

_____

Rate satisfaction of relationship with caregivers/family members (1-low;10-high):

Mom/mother figure Past:_____Present:_____ Still living: ☐ or Year died:_____

Dad/father figure Past:_____Present:_____ Still living: ☐ or Year died:_____

Other:_____ Past:_____Present:_____ Still living: ☐ or Year died:_____

Other:_____ Past:_____Present:_____ Still living: ☐ or Year died:_____

Other:_____ Past:_____Present:_____ Still living: ☐ or Year died:_____

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History of Self-harm/Suicide Ideation/Attempts (include dates/your age):_____

_____

History of Trauma/Abuse:_____

_____

List any legal issues or time served in prison:_____

_____

Current Medications

Name:_____ Dose:_____Date begun:_____Reason:_____

Name:_____ Dose:_____Date begun:_____Reason:_____

Name:_____ Dose:_____Date begun:_____Reason:_____

☐ Check here if taking >3 medications and submit separate list to include those

Significant Medical History (include chronic illness/pain, surgeries, disabilities, hospitalizations):_____

_____

_____

_____

Substance Use (select all that apply currently)

- ☐ None
- ☐ Past user (be specific):_____
- ☐ Alcohol _____Daily _____2-3/week ___Occasionally Number of drinks each time:_____
- ☐ Caffein _____Daily _____2-3/week ___Occasionally Number of drinks each time:_____
- ☐ Smoking/vaping _____Daily _____2-3/week ___Occasionally
- ☐ Marijuana _____Daily _____2-3/week ___Occasionally
- ☐ Other:_____ _____Daily _____2-3/week ___Occasionally

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Previous Mental Health Treatment (list year, length and focus of therapy, hospitalizations):

Main Social Supports:

List Hobbies/what you like to do for fun/recreation:

Briefly identify what you would like to receive from therapy:

Additional information you think helpful for treatment:

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Symptoms Checklist – Select/highlight all that apply

	Current Emotional Disturbances		**Current Interpersonal Disturbances**		**Suicide / Self-harm Assessment**
	Sad, depressed		Friendship betrayal		Active/current thoughts of suicide
	Hopeless		Work-place conflicts		Past thoughts of suicide
	Emotionally weary		Reputation smeared		Past attempt(s) of suicide
	Demotivated		Sexual/gender identity formation questions		Feeling others would be better off if I were dead
	Isolation		Spiritual questions		Active/current self-harming behaviors
	Loneliness		Relationship with significant other		Past self-harm (cutting, hitting, hair pulling)
	Irritability, hostility, anger		Cultural conflicts		**Physical Harm Assessment**
	Feeling worthless		Blended family challenges		I have weapons in my home
	Inability to regulate mood		Parenting issues		I fear for the safety of my family
	Current Stress/Anxiety		Relationship with parent / parent figure		I believe someone intends to physically harm me
	Restlessness, feeling keyed up or on edge		Significant life adjustment issues		I have persistent thoughts of harming another person
	Unwanted persistent/ intrusive thoughts		Relationship with siblings/other family		**Abuse / Trauma Assessment**
	Stress, worry		Discrimination / prejudice		Childhood physical/sexual abuse
	Anxiety/Panic attacks		**Current Physical Health Concerns**		Childhood emotional abuse
	Fearful or anxious		Loss of appetite		Intimate partner abuse
	Discomfort in social settings		Chronic fatigue, loss of energy		Abused in adulthood
	Fear of worst case scenario		Insomnia or trouble staying asleep		Online abuse
	Feeling out of control		Chronic health condition(s)		Sexual assault
	Current Self-Esteem/Body Image		Pain management		Witnessed or victim of crime
	Negative self-talk		Sexual performance issues		Cult/Occult abuse
	Perfectionism		Difficult pregnancy		Other traumatic event(s)
	Question my purpose in life		Physical limitation / disability		**Current Thought Patterns**
	Hate my body/uncomfortable in my own skin		Concern of catching illnesses from others		Trouble staying on task
	Low self-confidence and/or self-esteem		Other medical/physical issue		Habitual procrastination/Time management issues
	Rarely speak out / share my opinions		**Current Habitual Behaviors**		Frequent absence from work/school
	Grief and Loss Assessment		Compulsive sexual behaviors		Trouble expressing myself clearly in conversation
	Loss of pregnancy (abortion or miscarriage)		Regular use of pornography		Learning disabilities/difficulties (including AD/HD)
	Death of immediate (close) family member/friend		Overspending		Short-term memory loss or memory gaps of personal history
	Death of extended family member		Substance use/abuse		Hearing voices others don't
	Estranged from family member/ friend		"Caffein addict"		Told my behavior is odd or eccentric
	Loss of community		Smoker, vape user, tobacco use		Difficulty making decisions
	Loss of career / job opportunity or financial loss		Compulsive and/or emotional eating		Trouble setting and meeting personal goals
	Terminal illness/end of life concerns		Anorexia, bulimia		Seeing people or events others don't
	Loss of social support		Anger or rage outbursts		Poor concentration or focus

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Informed Consent and Disclosures (page 1 of 2)

Sign at the bottom of each page to signify you have read and understood each statement

California Civil Code Section, 56.10 states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without patient's consent. By initialing, you acknowledge/understand that I may contact either your current or former mental health care and/or medical providers to discuss issues relevant to your diagnosis and treatment without your consent.

Unless other arrangements have been made, the fee for service is $150 payable at time of session. If using insurance I accept, you will be liable to pay the contracted rate if there is lapse in coverage for any reason (otherwise your copay applies). Payment methods accepted are cash, check, all major credit cards and FSA cards. When using a credit or FSA card, a $2 service fee will be added to each transaction. Late cancellation fee of $75 applies to sessions cancelled with less than 12 hours notice.

Communication in the therapy session is kept confidential unless you grant written permission or as permitted by law. Exceptions to confidentiality include reporting suspected child, elder or dependent adult abuse. In addition, if you disclose information that leads me to believe you present a serious, imminent threat to yourself or another person, confidentiality will not apply.

"Brea Olinda Counseling Center" is a fictitious doing business as name (DBA) used by Julianne Maki, LMFT#24535 located in the same office suite and in no way indicates a partnership between this DBA and Christine Lister, LMFT.

Phone calls/text/email communication between sessions is to be limited to scheduling options only. I will return messages within a reasonable time frame during normal business hours M-F. Excessive communication between sessions including any lengthy emails will be billed at the regular hourly rate and will be pro-rated in 20-minute increments. In case of emergency, please call 911.

For Kaiser members, you may access the 24-hour crisis line at 800-900-3277 or the Orange County Regional Behavioral Health line at 714-644-6480

In the event of a personal emergency on my part, a representative may contact you. This person will not have access to your records and will only contact you if your appointment needs to be cancelled/rescheduled. The representative is not authorized to answer any detailed questions. In the event of my death, the representative will notify you of this news and provide referrals to other providers or refer you back to your insurance, whichever is applicable.

Sign:_____ Date:_____

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Informed Consent and Disclosures (page 2 of 2)

Parents or guardians of minors hold privilege and are entitled to information communicated by their children in psychotherapy. Ethics require me to communicate information regarding your child only in ways that will be helpful. This means details of a session might not be shared, but suggestions for how to handle certain situations may be discussed with parents.

I take a "no secrets" approach to family and couple counseling. This means when treating families or couples, information shared during an individual meeting or by phone may be shared in the group context at my discretion. To preserve relationship, I will coach an individual on how to disclose sensitive information to another family member. In the case of couples counseling, I will not continue to see either individual if the marriage dissolves.

I am trained to do a bi-lateral trauma resolution treatment similar to EMDR but am not certified by the EMDR Institute (for more information visit: www.EMDR.com). In the event that your issue constitutes trauma treatment, I will discuss this protocol with you before starting this type of therapy.

Consultations between therapists is common and considered good practice. In the event I share details concerning your case with other therapists, I will not disclose any identifiable details that would compromise your privacy.

I have been providing therapy services since 2015 and received my license in 2011. I take a collaborative approach where I invite you to actively participate in treatment goals/direction. My focus is two-fold: immediate symptom relief and historical root causes. I use interventions ranging from cognitive-behavioral strategies to mindfulness to family of origin exploration. If you have questions about this, we can discuss those in person.

There are risks and benefits of psychotherapy. Discussing disturbing events may cause additional distress before you feel better. It is recommended that you do not end therapy prematurely. My goal is to resource you before the end of each session to minimize any ill effects if/when you experience emotional disturbance. I trust you to inform me if you need more than what I focus on in each session.

I will store your number in my cell phone using your initials as a code. If you DO NOT want your number stored, initial here: _____

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Sign:_____ Date:_____

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Telehealth Informed Consent

In short, telehealth is any form of delivering health care via technology (e.g. video or phone).
Even if you are not currently receiving telehealth, please read and sign below to indicate you understand the options for telehealth and the risks associated with it.

1. Despite reasonable efforts on the part of my therapist my sessions could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

2. Miscommunication between myself and my therapist may occur via Telehealth. There is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

3. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

4. I understand that Telehealth may not be as effective or provide the same results as in-person therapy. There is no guarantee that Telehealth is effective for all individuals. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

5. Video/audio recordings of sessions will not occur without the other party's written permission.

6. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

Sign:_____ Date:_____

By signing above you acknowledge you have read and completed all 4 sections of this document:
Biopsychosocial, Symptoms Checklist, Informed Consent and Telehealth