Anna Cross MEd, LPC
Individual and Family Therapy

Welcome to the practice of Anna Cross, MEd, LPC. Please complete the forms as accurately and completely as possible before your first appointment. Doing so will maximize our time together. We can review any questions you may have during your first session.

Adult Information

Date: _____ Therapist's name: Anna Cross, MEd, LPC_____

Client's Name: _____

Age:_____ Date of Birth:_____

Home Address:_____

City: _____ State: _____ Zip: _____

Mailing Address (if different):

_____

City: _____ State: _____ Zip:_____

Cell Phone: _____ OK to Leave a Message? Y N

Work Phone: _____ OK to Leave a Message? Y N

Home Phone: _____ OK to Leave a Message? Y N

Email: _____ OK to Send a Message? Y N

Insurance Co: _____ Insurance Phone:_____

Subscriber ID: _____ Group #:_____

Name of Insured:_____D.O.B_____ Relationship: _____

Insured's
Address:_____Employer_____

3400 Bissonnet
Ste. 270
Houston TX 77005

Phone 713.582.5981
Fax 855.570.2235
anna@acrosstherapy.com

18700 W. Lake Houston
Pkwy. Ste.102
Humble TX 77346

I authorize Anna Cross, MEd, LPC to contact the person listed below in case of an emergency:

Name:_____ Number:_____

What is you marital status?

___Married ___Divorced ___Separated ___Single ___Other

Children (including ages):

_____
_____
_____
_____
_____

Please check your highest level of education.

___High School ___College ___Graduate ___Professional School

Occupation/Job Title:_____ Employer: _____

Presenting Problem:

What prompted you to seek counseling?

_____

How long has this been a significant concern for you?

_____

How has this problem affected you?

At home:_____

At school/work:_____Community:_____

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Please check which of the following symptoms you have experienced:
__overeating
__recent weight loss
__recent weight gain
__recent appetite changes
__restlessness
__rapid heart rate
__anxiety
__fears/phobias
__muscle tension
__compulsive behaviors
__obsessions
__taking drugs
__drinking alcohol
__shortness of breath
__sweating
__vomiting
__stomach problems
__chest pain
__pain
__dizzy or lightheaded
__odd behavior/thoughts
__trembling or shaking
__difficulty concentrating
__distrust
__aggressive behavior
__outbursts of temper
__low motivation
__social withdrawal
__feelings of worthlessness
__depressed mood
__thoughts of hurting self or others
__crying
__easily distracted
__fatigue/loss of energy
__nightmares
__sleeping too much
__decreased need for sleep
__difficulty falling asleep
__difficulty staying asleep
__family emotional problems
__relationship problems

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__housing problems
__financial problems
__problems with school
__experienced a traumatic event
__hearing voices/seeing things
__other: _____

Have you ever intentionally harmed yourself?_____

Attempted suicide?_____

Harmed others?_____

Psychiatric and Medical History:
Please list any psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs).
Diagnosis _____ Length of Stay __Treatment Response___

_____

_____

Please list any current or prior outpatient psychiatrists and therapists you have seen.
Name Title Location How Long_

_____

_____

Please list current **psychiatric** medications. Please attach a separate sheet if you need to list additional medication.
Name Dosage Duration Response__

_____

_____

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Please list current **non-psychiatric** medications.

Name Dosage Duration Response__

_____

_____

_____

Please describe any significant medical illnesses or diagnoses:

_____

I authorize Anna Cross, MEd, LPC to contact my primary care physician (PCP) to notify and coordinate care. _____ Yes _____ No _____NA

Doctor Name: _____ Phone:_____

2. I authorize Anna Cross, MEd, LPC to notify my psychiatrist to notify and coordinate care. _____ Yes _____ No _____NA

Doctor Name: _____ Phone:_____

Family History:

Please check if there is any family history of the following:

___Depression
___ADHD
___Schizophrenia
___Alcohol/Drug Problems
___Panic Disorder
___Psychiatric Hospitalizations
___Suicide (or attempts)
___Anxiety
___Bipolar (manic depressive)
___Mental Retardation
___"Nervous Breakdown"
___ PTSD-Post Traumatic Stress Disorder
___OCD-Obsessive Compulsive Disorder
___Pervasive Developmental Disorder

Personal Abuse History:

Have you ever been the victim of abuse or neglect? Yes No
If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical Emotional Neglect Sexual Witnessing violence

Other:_____

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Substance Use:

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your drinking? Yes No

How many alcoholic beverages do you consume each week on average? _____

How much tobacco do you smoke or chew each week?_____

Have you ever used prescription medication for purposes it was not intended?

_____

Have you ever used illegal drugs? _____

Other:

To what type of faith do you and/or your family adhere?

_____

What are your favorite activities?

_____

Who can you or family count on for support?

_____

In the past, what has been helpful in dealing with your issues?

_____

Is there anything else you feel is important for your therapist to know that we have not asked about on these forms?

_____

Client Signature:_____ **Date:**_____

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Acknowledgement and Consent

By signing this form:
(1) I acknowledge that I have been given a chance to review and ask questions about the Informed Consent and Practice Policies and Practices to Protect the Privacy of Your Health Information.
(2) I understand and agree to the stated practice polices as listed above and
(3) I give full consent for my minor child, or myself

_____, to participate in counseling.
(Print Client Name)

I certify that I have the legal right to seek and authorize treatment for my minor child or myself.

_____ _____
Client Signature (or parent/guardian if client is a minor) Date

_____
Print Name

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