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: ______________________________ Zip:__________
Street address and city

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:________________________________

____

____

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

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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Informed Consent and Disclosures

Initial after each to signify you have read and understood the 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. Initial: _________

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 $3 service fee will be added to each transaction. Late cancellation fee of $75 applies to sessions cancelled with less than 12 hours notice. Initial:_____________

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. Initial:___________

Brea Olinda Counseling Center is a fictitious "doing business as" name (DBA) used by another therapist located in the same office suite and in no way indicates a partnership between this DBA and Christine Lister, LMFT. Initial:___________

Phone calls, text or email communication between sessions is to be limited to scheduling options only. I will return messages within a reasonable time frame. 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 Initial:___________

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. Initial:___________

Parents or guardians of minors hold the 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. Initial:__________

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. Initial:______

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. Initial:______

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. Initial:_______

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. Initial:__________

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 3 sections of this document: Biopsychosocial, Informed Consent and Telehealth