

Inner Wisdom Counseling, L.L.C.
Initial Session Paperwork

Name: _____
(Last) (First) (Middle Initial)

Social Security Number: _____ - _____ - _____

Name of parent/guardian if you are a minor:

(Last) (First) (Middle Initial)

Social Security Number of Parent/Guardian: _____ - _____ - _____

Address:

(Street and Number) (City) (State) (Zip)

Home Phone: _____ - _____ - _____ May we leave a message? ___Yes ___No

Cell Phone: _____ - _____ - _____ May we leave a message? ___Yes ___No

Email: _____ May we email you? ___Yes ___No

*Please be aware that email may not be confidential. Your email will not be shared with anyone.

Birth Date: ____/____/____ Age: _____ Gender: ___ Male ___ Female ___ Transgender

Partner Status: ___ Single/ Not Partnered ___ Married ___ Partnered ___ Separated ___ Divorced
___ Dating ___ Widowed Length of relationship: _____

Number of Children: _____ Children's Name(s) and Age(s): _____

Referred by: _____

Primary Care Physician Name, Phone, and Address: _____

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Insurance Information:

___ Self-Pay ___ Medical Insurance

Primary Insurance Information:

Insured Name: _____

Client's relationship to the insured:

Insured SSN: _____ - _____ - _____

Self ___ Partner ___ Dependent

Insured Birth Date: ____/____/____

Member#: _____

Employer: _____

Policy Group #: _____

Payer/Health Plan: _____

Effective Date of Coverage: _____

Health and Social Information

Please List Specific Ethnicity/Race and check all that apply below: _____

Check all that apply: White/ European American Hispanic/ Latino(a)

Black/African American/African Asian American Pacific Islander

American Indian Middle Eastern Other: _____

Religion/Spirituality: _____ Actively Religious/Spiritual: Yes No

Sexual Orientation/ Identity: Heterosexual Gay/Lesbian Bisexual Questioning

Do you have any physical disabilities? No Yes, Please list: _____

Do you have any cognitive disabilities? No Yes, Please list: _____

Living Situation: I live alone Others in Household, List Names and relationships to

you: _____

Highest Education Level: High School G.E.D. Associate's Degree

Technical Degree Bachelor's Degree Graduate/Professional Degree or higher

Are you currently receiving psychiatric services, professional counseling, or psychotherapy services elsewhere? No Yes, Indicate Provider(s) _____

Have you had previous psychotherapy or professional counseling services?

No Yes, Indicate Provider(s) _____

Please list any medications, prescribed or over the counter that you are *currently* taking:

If you have currently or ever have taken prescribed psychiatric medication in the past, please list:

What brought you in to treatment today? _____

In the last year, have you experienced any significant life changes or stressors? _____

Are you currently having suicidal thoughts or any thoughts of harming yourself?

No Yes: Frequently Sometimes Rarely

Have you ever made a suicide attempt? No Yes

Are you currently having any thoughts of harming someone else?

No Yes: Frequently Sometimes Rarely

Symptoms/ Difficulties

Please indicate if you are currently experiencing any of the following symptoms or difficulties:

- | | |
|--|---|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Cutting or other self-injurious behavior |
| <input type="checkbox"/> Loss of interest in usual activities | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Fatigue or loss of energy | <input type="checkbox"/> Rapid speech |
| <input type="checkbox"/> Thoughts of worthlessness | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Impulsive behavior |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Disturbing dreams or memories |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Hallucinations or Delusions |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Alcohol or Substance abuse |
| <input type="checkbox"/> Changes in weight or appetite | |
|
 | |
| <input type="checkbox"/> Extreme anxiety | <input type="checkbox"/> Frequent bodily complaints (e.g., pain) |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Social anxiety | <input type="checkbox"/> Body Image problems |
| <input type="checkbox"/> Panic attacks | |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Repetitive thoughts (e.g., obsessions) |
| | <input type="checkbox"/> Repetitive behaviors (e.g., frequent checking, hand washing) |
| <input type="checkbox"/> Experiences of discrimination based on gender, race/ethnicity, age, (dis)ability, sexual orientation, class, size/weight, or other identity | <input type="checkbox"/> Difficulty controlling your temper |
| <input type="checkbox"/> Sexual harassment, sexual assault, or sexual abuse of self or other (past or present) | <input type="checkbox"/> Difficulties in romantic relationship |
| <input type="checkbox"/> Unwanted sexual contact | <input type="checkbox"/> Difficulties with job or school performance |
| <input type="checkbox"/> Violence in your home | <input type="checkbox"/> Work related stressors |
| <input type="checkbox"/> Verbal or Emotional abuse | <input type="checkbox"/> Complaints about your behavior from friends, work, family, or others |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Difficulties with friendships |
| <input type="checkbox"/> Victim of a crime | <input type="checkbox"/> Difficulties with family relationships |
| <input type="checkbox"/> Trauma History | <input type="checkbox"/> Difficulties with sexual functioning |
| | <input type="checkbox"/> Other _____ |

Other Health and Social Information continued

Please list how often you currently drink alcoholic beverages: _____drinks per _____Day/Week/Month (circle one)

How often have you drank during a time of highest usage: _____drinks per _____Day/Week/Month (circle one)

Please list any current recreational drug use: _____

Please list any past recreational drug use: _____

Please list any persistent medical symptoms, current medical diagnoses, hospitalizations, surgeries, or health concerns (e.g., chronic pain, headaches, hypertension, smoker, diabetes): _____

Are you having any difficulty with your sleep habits? No Yes

If Yes: Too Much Too Little Poor Quality Sleep Other: _____

Are you having any difficulty with appetite, weight gain or loss, or eating habits? No Yes

If Yes: Eating Less Eating More Bingeing Restricting
 Purging (e.g, vomiting, diet pills, laxatives) Exercising Excessively

How many times per week do you exercise? _____ Approximately how long each time? _____

How would you rate your support system (e.g., partner/spouse, friends, family, extended family, coworkers)?

Excellent Good Fair Poor

Do you have any family history of psychiatric difficulties that you know of? No Yes

If Yes, Please list: _____

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What do you do for fun? _____

What are effective coping strategies you've learned? _____

What are your goals for therapy? _____

Is there anything else you would like to share? _____

I have read, received a copy of, and understand the "Professional Agreement and Consent to Treatment" paperwork. I understand that this includes: the approach to treatment, financial terms, policy regarding missed appointments, emergency procedures, and the limits to confidentiality. I understand that I am ultimately financially responsible for all incurred bills. I also have read, understand, and have been offered a copy of "Notice of Privacy Practices" and understand my health care rights and responsibilities. I understand the possible risks and benefits and I fully consent to treatment with Dr. Linda Najjar. If I choose to have an insurance carrier billed for services, I authorize the release of information regarding my care to my health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan. I authorize payment of medical benefits to Linda Najjar, Ph.D., Inner Wisdom Counseling, L.L.C. All my questions/concerns about all services and all paperwork have been addressed.

(Printed Name of Patient)

(Signature)

(Date)

(Printed Name of Guardian if patient is a minor)

(Signature)

(Date)