**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 and Phone#:_____

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

Insurance Information:
____ Self-Pay ____ Medical Insurance

Primary Insurance Information:

Policy Holder's Name: _____ Client's relationship to the policy holder:
Policy Holder's SSN: _____-_____-_____ ___Self ___ Partner ___ Dependent
Policy Holder's 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: ____ Middle School ____ 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 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:

____Depressed mood
____Loss of interest in usual activities
____Fatigue or loss of energy
____Thoughts of worthlessness
____Difficulty concentrating
____Excessive guilt
____Excessive worry
____Difficulty sleeping
____Changes in weight or appetite

____Anxiety
____Restlessness
____Social anxiety
____Panic attacks
____Phobias

____ Experiences of discrimination based on gender, race/ethnicity, age, (dis)ability, sexual orientation, class, size/weight, or other identity
____Sexual harassment, sexual assault, or sexual abuse of self or other (past or present)
____Unwanted sexual contact
____Violence in your home
____Verbal or Emotional abuse
____Physical abuse
____Victim of a crime
____Trauma History

____Cutting or other self-injurious behavior

____Mood swings
____Rapid speech
____Racing thoughts
____Impulsive behavior
____Disturbing dreams or memories
____Hallucinations or Delusions
____Alcohol or Substance abuse

____Frequent bodily complaints (e.g., pain)
____Eating disorder
____Body Image problems

____Repetitive thoughts (e.g., obsessions)
____Repetitive behaviors (e.g., frequent checking, hand washing)

____Difficulty controlling your temper
____Difficulties in romantic relationship
____Difficulties with job or school performance
____Work related stressors
____Complaints about your behavior from friends, work, family, or others
____Difficulties with friendships
____Difficulties with family relationships
____Difficulties with sexual functioning
____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)

**Inner Wisdom Counseling, L.L.C.**
**Linda Najjar, Ph.D.**

**CONSENT FOR RELEASE OF INFORMATION**

I give consent for Inner Wisdom Counseling, L.L.C./Dr. Linda Najjar and the healthcare provider or other party listed below to exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for coordination of treatment, case management, claims processing, quality assurance, or utilization review purposes.

I understand that I can revoke my consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

**I have read and I understand the information above and I authorize Dr. Linda Najjar to contact and exchange information with:**

Name of Primary Care Physician or other Person to whom you want to Release Information:

_____

Telephone: _____-_____-_____ Fax: _____-_____-_____

List any limits on release of information or additional requests if needed:

_____

_____

**_____ I choose not to provide consent for release of information.**

_____

(Printed Name of Patient) (Signature) (Date)

_____

(Printed Name of Guardian if patient is a minor) (Signature) (Date)