

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

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
(Street and Number) (City) (State) (Zip)

Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Is it okay to leave a message? \_\_\_Yes \_\_\_No

Do you give permission for text message reminders for appointments? \_\_\_Yes \_\_\_No

Email: \_\_\_\_\_ Is it okay to email you? \_\_\_Yes \_\_\_No

Referred by: \_\_\_\_\_

Primary Care Physician Name and Phone#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Relationship) (Phone Number)

Insurance Information: \_\_\_ Self-Pay \_\_\_ Medical Insurance

Client's relationship to the policy holder: \_\_\_ Self \_\_\_ Partner \_\_\_ Dependent  
If Policy Holder is not self: Policy Holder's Name: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Policy Holder's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Health and Social Information

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Preferred Pronouns: \_\_\_ she/her \_\_\_ he/him \_\_\_ they/them

Gender: \_\_\_ Male \_\_\_ Female \_\_\_ Transgender: \_\_\_ M>F \_\_\_ F>M \_\_\_ Gender Fluid \_\_\_ Other: \_\_\_\_\_

Partner Status: \_\_\_ Single/ Not Partnered \_\_\_ Married \_\_\_ Partnered \_\_\_ Separated \_\_\_ Divorced  
\_\_\_ Dating \_\_\_ Widowed \_\_\_ Open/ Polyamorous Length of relationship(s): \_\_\_\_\_

Number of Children: \_\_\_\_ Children's Name(s) and Age(s): \_\_\_\_\_

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

- \_\_\_ White/ European American \_\_\_ Hispanic/ Latino(a)/ Chicano(a) \_\_\_ American Indian
- \_\_\_ Black/ African American/ African \_\_\_ Asian American \_\_\_ Pacific Islander
- \_\_\_ Middle Eastern or Arab American \_\_\_ Other: \_\_\_\_\_

Religion/Spirituality: \_\_\_\_\_ Actively Religious/Spiritual: \_\_\_Yes \_\_\_No

Sexual Orientation/ Identity: \_\_\_ Heterosexual \_\_\_ Gay/Lesbian \_\_\_ Bisexual \_\_\_ Questioning \_\_\_ Queer  
\_\_\_ Pansexual \_\_\_ Other: \_\_\_\_\_

Do you have any physical or 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

Occupation: \_\_\_\_\_

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 psychiatric or psychotropic medications, prescribed or over the counter that you are *currently* taking: \_\_\_\_\_

\_\_\_\_\_

Psychiatric or psychotropic medication that you have taken in the past: \_\_\_\_\_

\_\_\_\_\_

What brought you in to treatment today? \_\_\_\_\_

\_\_\_\_\_

If you have experienced any significant life changes or stressors within the past year, please list:

\_\_\_\_\_

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: \_\_\_\_\_

## Symptoms/ Difficulties

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

- |  |   |
|--|---|
| <input type="checkbox"/> Depressed mood  | <input type="checkbox"/> Rapid speech   |
| <input type="checkbox"/> Loss of interest in usual activities  | <input type="checkbox"/> Pressure to keep talking   |
| <input type="checkbox"/> Fatigue or loss of energy   | <input type="checkbox"/> Racing thoughts  |
| <input type="checkbox"/> Thoughts of worthlessness   | <input type="checkbox"/> Drastic mood swings  |
| <input type="checkbox"/> Low self-esteem   | <input type="checkbox"/> Periods of euphoria  |
| <input type="checkbox"/> Difficulty concentrating  | <input type="checkbox"/> Periods of hyperactivity   |
| <input type="checkbox"/> Excessive guilt   | <input type="checkbox"/> Periods of extreme irritability or aggression                              |
| <input type="checkbox"/> Difficulty sleeping   | <input type="checkbox"/> Periods of excess energy or activity                                       |
| <input type="checkbox"/> Changes in weight or appetite   | <input type="checkbox"/> Periods of excessive spending  |
| <input type="checkbox"/> Thoughts of death or dying  |   |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Phobias: _____   |
| <input type="checkbox"/> Excessive worry   | <input type="checkbox"/> Easily distracted  |
| <input type="checkbox"/> Difficulty controlling worry  | <input type="checkbox"/> Impulsive behavior   |
| <input type="checkbox"/> Restlessness/ feeling fidgety   | <input type="checkbox"/> Destructive behavior   |
| <input type="checkbox"/> Irritability  | <input type="checkbox"/> Hallucinations or Delusions  |
| <input type="checkbox"/> Social anxiety  |   |
| <input type="checkbox"/> Panic attacks   | <input type="checkbox"/> Problems w/ attention span   |
| <input type="checkbox"/> Difficulty leaving home   | <input type="checkbox"/> Eating disorder/ problematic eating  |
|  | <input type="checkbox"/> Body Image problems  |
| <input type="checkbox"/> Experiences of discrimination based on gender, race/ethnicity, age, (dis)ability, sexual orientation, class, size/weight, citizenship status, or other identity | <input type="checkbox"/> Repetitive thoughts (e.g., obsessions)                                     |
| <input type="checkbox"/> Sexual harassment, sexual assault, or sexual abuse of self or other (past or present)   | <input type="checkbox"/> Repetitive behaviors (e.g., frequent checking, hand washing, skin picking) |
| <input type="checkbox"/> Unwanted sexual contact   |   |
| <input type="checkbox"/> Violence in your home   | <input type="checkbox"/> Difficulty controlling your temper   |
| <input type="checkbox"/> Verbal or Emotional abuse   | <input type="checkbox"/> Difficulties in romantic relationship                                      |
| <input type="checkbox"/> Physical abuse  | <input type="checkbox"/> Difficulties with job or school performance                                |
| <input type="checkbox"/> Victim of a crime   | <input type="checkbox"/> Work related stressors   |
| <input type="checkbox"/> Trauma History  | <input type="checkbox"/> Complaints about your behavior from friends, work, family, or others       |
| <input type="checkbox"/> Intrusive or disturbing memories or flashbacks  | <input type="checkbox"/> Difficulties with friendships  |
| <input type="checkbox"/> Easy startle response   | <input type="checkbox"/> Difficulties with family relationships                                     |
| <input type="checkbox"/> Hypervigilance  | <input type="checkbox"/> Difficulties with sexual functioning                                       |
| <input type="checkbox"/> Avoidance of traumatic triggers   |   |
| <input type="checkbox"/> Disturbing dreams or nightmares   | <input type="checkbox"/> Infertility of self or partner   |
|  | <input type="checkbox"/> Miscarriage  |
| <input type="checkbox"/> Alcohol or Substance abuse  | <input type="checkbox"/> Post-partum depression   |
| <input type="checkbox"/> Cutting or other self-injurious behavior  | <input type="checkbox"/> Pregnancy-related issues   |
|  | <input type="checkbox"/> Prior psychiatric hospitalization(s)                                       |
|  | <input type="checkbox"/> Other _____  |

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

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 physical health concerns (e.g., chronic pain, headaches, hypertension, smoker, diabetes): \_\_\_\_\_

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)

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/ Organization to whom you want to Release Information:

\_\_\_\_\_

Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ I would prefer if the release of information was only used if absolutely needed/  
requested by my primary care doctor or other person.

\_\_\_\_\_ I choose not to provide consent for release of information to anyone at this time.

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