Meaning~Options~Empowerment

Welcome to Inner Directions Counseling. Please fill this out as completely as possible and have it ready before your next counseling session. Feel free to use the back as necessary.

# Client Information

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer (if working outside the home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Messages OK at home? Yes No

Phone (cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Messages OK on cell? Yes No

Text (scheduling & brief check in only) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Text OK? Yes No

Phone (work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Messages OK at work? Yes No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emails OK? Yes No

**(Note: *I cannot guarantee the confidentiality of e-mail.*)**

Newsletter? Yes No Follow-up e-mail: Yes No

(Please check all that apply)

\_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced

\_\_\_ Cohabiting \_\_\_ Engaged \_\_\_ Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religious/Spiritual Affiliation:\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnic/Cultural Heritage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish to have your Spirituality integrated into your therapy? \_\_\_Yes \_\_\_No

**Risk Areas:**

**Homicidal Ideation**: Yes: \_\_\_ No: \_\_\_\_ Past (when):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suicidal Ideation**: Yes: \_\_\_ No: \_\_\_ Past (when):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Couple Violence**: Yes: \_\_\_ No: \_\_\_\_\_ Past (when): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Usage**: (Circle all that apply)

Current: Alcohol Nicotine Caffeine Marijuana Cocaine Other: \_\_\_\_\_\_\_\_\_\_\_\_

Past: Alcohol Nicotine Caffeine Marijuana Cocaine Other: \_\_\_\_\_\_\_\_\_\_\_\_

History of Substance Abuse Treatment? \_\_\_ Yes \_\_\_ No

**Sexuality**

Partner Preference: \_\_\_Hetero\_\_\_SameSex \_\_\_Both

Activity \_\_\_\_ x/mo Energy Level \_\_\_\_ (1-10) Partner’s Level \_\_\_ 1-10

#### Partner & Children

If in a Primary Relationship, Name of your Partner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If living together, how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If married, how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If there are children from this relationship, please indicate:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

**If previously married, please indicate:**

Name of Former Years Date of Marriage Reason Marriage

Spouse Married termination ended

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If there are children by Previous Marriages or Primary Relations, Please indicate:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

### Siblings & Parents

**If any Brothers & Sisters, (Including those Deceased), Please Indicate:**

# First Name Age Gender Education Marital Status Occupation

***\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Father’s** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education:\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religious Affiliation, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education:\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religious Affiliation, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Was either parent married more than once? Please give details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Strengths:**

What do you do well, and what activities do you enjoy?

What personal qualities would others say you have?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe.)

# Medical/Counseling History

**Medical:**

Name of Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medical issues or diagnoses do you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are taking any medications, what are they:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to let me contact your primary care physician? \_\_\_\_Yes \_\_\_ No

Do you have other medical concerns or previous hospitalizations? Please describe.

**Counseling:**

Have you previously seen a ***therapist/counselor***? \_\_\_Yes \_\_\_No

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for stopping services?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used ***psychiatric services***? \_\_\_Yes \_\_\_No Helpful?\_\_\_ Yes \_\_\_No

Please describe.

Have you taken ***medication*** for a mental health concern? \_\_\_Yes \_\_\_No

|  |
| --- |
| Name of medication Dates Taken Helpful? (Y/N) |
|  |
|  |
|  |

May I contact your previous provider(s): \_\_\_Yes \_\_\_No

# For Couples Counseling

Please check any current couple concerns that you are having.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Fighting | |  |  | Disagreeing about Relatives | | |
|  | Feeling Distant | |  |  | Disagreeing about Friends | | |
|  | Loss of fun |  |  |  | Alcohol Use | |  |
|  | Sexual concerns | |  |  | Drug Use |  |  |
|  | Violence |  |  |  | Infidelity |  |  |
|  | Lack of Intimacy | |  |  | Other |  |  |
|  | Money |  |  |  | Other |  |  |

# Individual Concerns

Please check any current personal concerns that you are having and circle anything you’ve experienced in the last two weeks:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Abuse (adult) |  | Hurting others |  | Nausea |  |
| Abuse (childhood) |  | Hurting self |  | Nightmares |  |
| Alcohol Use |  | Hypervigilence |  | Obsessions |  |
| Anger/rage |  | Fear |  | Other |  |
| Another's Alcohol User |  | Fear of being judged negatively |  | Palpitations |  |
| Another's Drug Use |  | Fear of dying |  | Panic |  |
| Anxiety |  | Fear of losing control |  | Panic attacks |  |
| Appetite change |  | Flashbacks |  | Restlessness |  |
| Avoiding people |  | Grief/loss |  | Sadness |  |
| Avoiding places |  | Guilt |  | Seeing things |  |
| Chest pain |  | Hearing things |  | Self criticism |  |
| Chills |  | Hopelessness |  | Shortness of breath |  |
| Compulsions |  | Hot flashes |  | Sleep problems |  |
| Concentration |  | Increased startle response |  | Spirituality issues |  |
| Crying spells |  | Irritability |  | Suicidal acts |  |
| Derealization |  | Light-headed |  | Suicidal thoughts |  |
| Distractible |  | Loneliness |  | Trembling |  |
| Drug Use |  | Loss of pleasure |  | Weight gain/loss |  |
| Easily fatigued |  | Mood swings |  | Work issues |  |
| Eating problems |  | Muscle tension |  | Worthlessness |  |

**Where do you experience these symptoms (check all that apply):**

\_\_ work \_\_\_ home \_\_\_ socially \_\_\_ other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Legal Issues

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

## Additional Information

Is there anything else that might be helpful for me to know?

**How will you know that therapy is successful? Do you have particular goal for your therapeutic work?**