Confidential Self-Report

Mindful Inspiration Counseling, LLC

GENERAL INFORMATION:

Full Name: _____ SSN: _____
Today's Date: _____ Date of Birth: _____
Sex: _____ Age: _____
Occupation: _____ Employer: _____
Referred by: _____

CONTACT INFORMATION:

Address:

_____

City: _____ State: _____ Zip Code: _____

May we send mail here? Yes ❑No ❑

Phone Number: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____
Phone Number: _____

PAYMENT/INSURANCE:

Self Pay: Yes ❑No ❑

Employee Assistance Program: Yes ❑No ❑ Authorization #_____

Insurance: Yes ❑No ❑ Insurance Carrier_____
Policy Number: _____ Group Number: _____
Name of Insurer_____ DOB of Insurer: _____

RELATIONAL AND LIFESTYLE:

Current Marital Status: Single ❑Engaged ❑Married ❑Separated ❑Divorced ❑

Widowed ❑

Who currently lives with you?

_____

Do you have a personal support system? Yes ❑No ❑

Do you exercise regularly? Yes ❑No ❑

What do you do for leisure? _____

RELIGION/SPIRITUALITY:

Do you identify with a religion? If so, which one?

_____

Are you practicing? Yes ❑No ❑

Do you consider yourself spiritual? Yes ❑No ❑

PRESENTING ISSUES AND GOALS:

Please describe why you have decided to seek services:

_____

_____

What do you hope to gain or change by coming for counseling?

_____

LEVEL OF DISTRESS:

On a scale from 1-10 how distressed are you?

_____

(1= very little distress; 10= Extreme Distress)

Are you currently experiencing any suicidal thoughts? Yes ❑No ❑

Have you previously experienced suicidal thoughts? Yes ❑No ❑

If yes, please describe, including when:

_____

Have you ever attempted suicide? Yes ❑No ❑

If yes, please describe, including when:

_____

PREVIOUS COUNSELING and MEDICAL HISTORY:

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received:

Therapist: _____ Location:_____
Dates:_____ Reason/Diagnosis:_____

Please list any current medications:

_____

Name of primary care physician:

_____

Is there any history in your family (including your parents, children, and spouse) of chronic illness, mental illness, suicide, alcohol or drug problems, abuse (physical, emotional, sexual), or violent or criminal behavior?

Yes ❑No ❑

If yes, please describe:

_____

Please check any of the following symptoms that apply to you presently or in the recent past:

	Current	**Past**
Headaches	❑	❑
Visual Trouble	❑	❑
Weakness	❑	❑
Difficulty Breathing	❑	❑
Change in Appetite	❑	❑
Hearing Voices	❑	❑
Fatigue	❑	❑
Seeing Things	❑	❑
Feelings of Depression	❑	❑
Anxiety	❑	❑
Excessive Crying	❑	❑

Anger Issues	❑	❑
Nightmares	❑	❑
Unwanted Thoughts	❑	❑
Impulsive Behavior	❑	❑
Sexual Problems	❑	❑
Legal Issues	❑	❑
Substance Abuse	❑	❑