WHOLE HEALTH PLUS INTAKE FORM	**Internal Use Only** Today's Date & Time: _____ DSM IV, Axis I Code: _____ Circle Type: I, C, F, G or Assessment Only

1. NAME: _____ D.O.B. _____

2. Reasons for contacting me? _____

3. Goals and Outcomes: By the end of counseling what do you hope to feel, see, do, understand, express, or implement/plan better or differently?

   _____

4. Hobbies, outlets and strengths? _____

5. Biggest Supporters? _____

6. Prior or strained significant relationships? (i.e. x's, in-laws, family, friends)? Y/N?
   If yes, please indicate who and what was the cause of the break up or strain between your family, friend's or x's. _____

7. Prior therapy dates and reasons? _____

8. What have you tried before to help you with your problems? _____

   _____

9. Work history: Currently employed? Y/N? Level of work satisfaction? 1) Enjoy 2) Tolerate or 3) Dislike/high Stress. Hours? Day, evenings, 3rd shift? Amount of life job changes? 1) 0-5 2) 6-10, 3) 11-30. Trouble finding work? Y/N? Participate in volunteer work? Y/N? Stay at home parent? Y/N? Taking care of elderly parents or disabled children? Y/N?

10. How well do you function with daily responsibilities using 0-10 scale (10 highest)? _____

11. Substance abuse history: Check current or prior use or abuse of: __alcohol, __drugs, __vaping, __controlled substances/prescription drugs, __energy drinks, __coffee, __soda, __junk food/sugar? If Yes, please indicate date first used _____? last used _____? and how often used in the past month? _____ Where do you get it from? _____
    Consequences of using? _____
    Do you feel shame and wish you could stop? Y/N Attempts made to stop? __1-10, __10+

12. Has your addiction affected your responsibilities, functioning, financial status or has anyone complained about your substance abuse? Y/N? Have you sought help in the past? Y/N?

13. Dealing with pornography addiction current or in past? _____ Same-sex attraction? Y/N? Indicate age first struggled _____? Date last tempted _____? How often fixated or indulged in the past month or year? ___ Do you feel empty, shame and wish you could stop? Y/N? Have you sought help in the past Y/N? Attempts made to stop? __1-10? __10+

14. Does your internet use, social media or gaming use interfere with your responsibilities, relationships and face to face connections? Y/N? Have you tried to decrease or stop? Y/N?

15. Favorite ways to move or exercise? _____ How often do you exercise, stretch or move around per week? _____ Do you have a set exercise routine? Y/N?

16. Religious or spiritual identification and regular practices? _____

17. How do you cope with stress or problems? _____

18. Identify any unhealthy eating or drinking habits and appetite changes such as eating less or more than usual, emotional eating, binge eating or drinking. _____
_____

19. Check off any current sleep problems: __insomnia, __lethargy, __exhaustion, __sleeping too much, __sleeping too little, __trouble getting to sleep, __racing thoughts at night, __waking up in middle of night, __sleep apnea, __nightmares or terrors, other: _____

20. When you feel stress, fear, anxiety, or other emotions how mindful are you of how it effects your body? Circle: Not at all, Sometimes, Most of the time, or Always.

21. Name a current feeling or struggle, do a quick body scan now and write down where in your body you feel any tightness, pain, worry, sadness, fear, anger, resentment, guilt, shame, anxiety, stress, etc. _____ Describe what it feels like and looks like. _____

22. Name past or current psychiatric diagnosis or list any current problems with symptoms of anxiety, depression, PTSD, ADHD, etc.? _____
_____

23. How long have you struggled with this problem? Year or month started noticing: _____
Circle how well you can function despite this problem? a) Not at all b) Poor c) Okay d) Good
Age and Triggers when symptoms first started? _____
Circle intensity of symptoms: a) Severe b) Moderate c) Mild When worse? _____
How long and consecutive are the symptoms? ___Days? ___Weeks? ___Months? ___ Years?

24. List some of the most significant childhood and adult experiences that are contributing to your current health status and functioning? _____
_____

25. Have you or your children ever been abused sexually, physically, spiritually, or mentally before? Y/N? If yes when _____, how often _____ and by whom? _____
Were any police or DSS authorities notified and any legal action taken? Y/N?

26. What are your biggest relationship struggles? _____

27. What are interaction styles you use in your relationship? __criticize & defend or attack, __ tune out, withdraw or isolate, __ passive-aggressive, __contempt & judgmental, __compare/jealousy, __fight & argue/no breaks, __avoid & give up, __heated & smothering, __appease/placate & hold in thru feelings. __sarcasm/joke, __cater while ignoring own needs

28. Feeling distant, isolated or disconnected to others and/or God? Y/N? What are you currently spiritually struggling with? _____

29. What % are you ready and motivated to do the work to make the necessary changes to achieve your goals? _____ Please write any story, worries, worst fears, negative thinking, obstacles, people, cultural dogma or beliefs holding you back from your goals. _____
_____

30. List any other addiction, unhealthy habits/patterns, relationship struggles, or stressors not listed already that would be helpful information. _____
_____

31. Indicate any needs or boundaries that you are missing in your life? __setting limits/saying no, __ rest and time for nurturing for self or __close relationships, __financial/budgeting, __freedom, __power/ control, __spiritual, __work, __intimacy/connection, __fun, __parenting, __meaning/ purpose, __support __accomplishment, __educational, __affection, __love and belonging __respect, __a vacation/ break, __other_____.

32. **Current SUICIDAL THOUGHTS, PLANS, MEANS or INTENTIONS or DEATH WISH** *such as "I wish this all would end." or "I am done with life" or "Others including me would be better off if I was dead"* ***Y/N****?* **If yes, do you have any means, plans, ideas, hopes, intents to hurt yourself**? **Y/N**? IF yes, explain your means and plans or indicate if it is just a wish? _____

Do you want to set boundaries with these thoughts to decrease your death wish? **Y/N?**
Do you want to increase your life wish and find more meaning, joy and pleasure in life**? Y/N?**
Do you have a safety or crisis plan or a trusted friend to reach out to? **Y/N?**
How likely are you to follow the safety plan of the WHP policies? 0 (not) – 10 (extremely) _____

AUTO BIOGRAPHY – What's your story?

Please write a brief biography including trauma/abuse, family, changes, significant events, relationships, marriages, childhood, religious/cultural upbringing, etc.

Include ages of each event (i.e. Age 2 – neglected by mother, 5 – moved, 6 – parents divorced)
Include losses (i.e. Deaths, Job Change, Rape, Divorces, Illness /Accidents, etc.):

PLEASE CIRCLE OR CHECK ANY ISSUE THAT PERTAINS TO YOU

Anxiety	Anger	Addictive Behaviors	Alcohol Use Tobacco Use	Attachment Intimacy
Attention /ADHD	Current trauma/ Abuse	Concentration Focus Forgetfulness	Communication problems	Career/work
Depression	Drug Use	Eating/food/Weight concerns	Energy levels/ Fatigue	Family Problems
Finances	Health	Loss and Grief	Legal Matters	Loneliness
Marital or relationship issues	Mania High Energy	OCD Paranoia Perfectionism	Personal Growth Goals Parenting	Pornography or Internet Addiction
Panic attacks	Pain	Past Traumas or Abuse History	Racing Thoughts	Sleep Disturbances
Self esteem	Stress	Suicidal thoughts	Sexuality issues	Self-harm
Spiritual struggles	Shame	School or Bullying	Somatic and Medical Issues	Worried Fearful

In the last 2 weeks, mark from 0-10 how intense you experienced any of these symptoms: (i.e. 0=none, 1=little, 5= moderate, 8 = extreme, 10 = disabling)

___ sad, depressed, tearful	___ angry, hostile, upset	___ anxious, worried, nervous
___ resentful, bitter	___ irritable, moody, edgy	___ disinterested, unmotivated
___ overwhelmed, stressed	___ numb, empty, withdrawn	_____ hurt, pain, disappointed
___ fearful, apprehensive, unsure	___ worthless, hopeless	___ tired, fatigued, low energy
___ shame, guilt, self-blame	___ changes in appetite	___ agitated, easily annoyed
___ powerless, frustrated	___ grief, loss, pain	___ detached or isolated from others and the world
___ distracted, unfocused	___ impulsive, hasty, fidgety	___ fidgety, ___ forgetful
___ insomnia, ___ hypersomnia	___ manic, lots of do lists	___ flashbacks, startle easy
___ obsessions, intrusive, unwanted thoughts, paranoid	___ compulsions, driven (i.e. to clean, check, eat, scratch, touch, ingest, view)	___ panic attacks (dizzy/shaky, chest pounding/pain, out of breath, sweating, nausea)
___ suicidal or death wish	___ chronic pain, ailments	__ Headaches __Stomachaches