River Bend Therapy, LLC
Michelle Hallinan, LCSW
320 Century Drive
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Initial Session Questionnaire

Please use additional paper as needed to answer these questions prior to our first meeting

Name: _____ DOB:_____

Date: _____ How did you learn of me:_____

Phone(s):_____

Address: _____ Email:_____

Emergency Contact/Relationship:_____ Emergency Contact Phone:_____

Occupation:_____

Current concerns/reasons for seeking counseling at this time:

_____

_____

_____

_____

Origins/history/background of this concern(s)/ Have you experienced anything similar in the past:

_____

_____

_____

_____

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Outcome you hope for from counseling:

_____

_____

_____

Married/Partnered status: _____ Children/Ages: _____

Who lives with you:_____

Your relationship to your current family members (spouse, children, etc.):

_____

_____

_____

Career history:

_____

_____

_____

Satisfaction with your current employment:

_____

_____

Current or ongoing physical health issues:

_____

_____

Medicines you take regularly/purpose:

_____

_____

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Prior counseling experience: Yes _____ No _____ With whom: _____How /why/when did prior counseling end:

_____

_____

Anything else regarding your physical/mental health that I should know (prior mental health diagnoses, family history, concerns, etc.):

_____

_____

_____

_____

Who was in your family growing up (include any changes to family situation/your age):

_____

_____

Anything else I should know about your family of origin from the outset:

_____

_____

Are you in a romantic relationship now? **Y** **N** If so, is the relationship fulfilling? If not, how does this impact you?

_____

_____

_____

_____

We all have good and bad days. How are you when you are at your best in relationship with another:

_____

_____

_____

_____

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At your worst in relationship with another:

_____

_____

Whom/what do you currently turn to when you need support:

_____

_____

Do you feel adequately supported in your life? **Y** **N** If not, what is lacking:

_____

_____

What activities do you feel nourished by:

_____

_____

What inner strengths/qualities do you use in difficult times:

_____

_____

What other information would be helpful for me to know (how you self-identify, gender, sexuality, addiction, suicidal ideation or attempts, depression, anxiety, life events, trauma, self harm, spirituality/religion, cultural background, which substances or activities you engage in to feel better, etc.):

_____

_____

_____

_____

_____

_____

_____

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NOTE: The information below is helpful to me in that it lets me see a larger picture of what is happening in your life and gives me insight into items that may never otherwise be brought into counseling. However, if this feels excessive to you, I urge you to only spend as much time on this form as you wish.

Please rate the impact on you of each of the following symptoms – the rating scale is:

0 = none	1= a little	2= some	3= moderate	4 = large	5= severe

Physical

1. Difficulty falling asleep	0 1 2 3 4 5
2. Early waking	0 1 2 3 4 5
3. Oversleeping	0 1 2 3 4 5
4. Exhaustion/chronic fatigue	0 1 2 3 4 5
5. Hyperactivity	0 1 2 3 4 5
6. Feeling weightless	0 1 2 3 4 5
7. Feeling physically weighed down	0 1 2 3 4 5
8. Reduced range of motion	0 1 2 3 4 5
9. Panic attacks	0 1 2 3 4 5
10. Generalized physical anxiety	0 1 2 3 4 5
11. Nausea/vomiting	0 1 2 3 4 5
12. Tingling energy in body	0 1 2 3 4 5
13. Overeating	0 1 2 3 4 5
14. Undereating	0 1 2 3 4 5
15. Recurring tension in _____	0 1 2 3 4 5
16. Chronic pain felt in _____	0 1 2 3 4 5
17. Loss of sexual interest	0 1 2 3 4 5
18. Heightened sexual interest	0 1 2 3 4 5
19. Dizziness	0 1 2 3 4 5
20. Depression	0 1 2 3 4 5
21. Apathy towards life	0 1 2 3 4 5
22. Sound or light hypersensitivity	0 1 2 3 4 5
23. Heart pounding	0 1 2 3 4 5
24. Physical Numbness	0 1 2 3 4 5
25. Shouting/ hitting -kicking/ screaming/ throwing objects/ temper outbursts (Circle those that apply)	0 1 2 3 4 5

Emotional

40. Worry	0 1 2 3 4 5
41. Helplessness; powerlessness	0 1 2 3 4 5
42. Feeling out of control/overwhelmed	0 1 2 3 4 5
43. Feeling frozen or paralyzed	0 1 2 3 4 5
44. Extreme shifts in mood	0 1 2 3 4 5
45. Rage	0 1 2 3 4 5
46. Over-cautiousness	0 1 2 3 4 5
47. Fear of being watched/ followed	0 1 2 3 4 5
48. Heightened startle response	0 1 2 3 4 5
49. Fearlessness in dangerous situations	0 1 2 3 4 5
50. Feeling defeated/ inadequate	0 1 2 3 4 5
51. Confusion	0 1 2 3 4 5
52. Feeling fragmented	0 1 2 3 4 5
53. Restlessness	0 1 2 3 4 5
54. Trouble orienting yourself in time/space	0 1 2 3 4 5
55. Shame	0 1 2 3 4 5
56. Self-judgment	0 1 2 3 4 5
57. Self-blame	0 1 2 3 4 5
58. Always on alert/hypervigilent	0 1 2 3 4 5
59. Desire to harm self or others	0 1 2 3 4 5
60. Wanting to run away	0 1 2 3 4 5
61. Crying easily	0 1 2 3 4 5
62. Inability to cry	0 1 2 3 4 5
63. Irritability/overreacting	0 1 2 3 4 5
64. Waiting for other shoe to fall	0 1 2 3 4 5
65. Worthlessness	0 1 2 3 4 5

Mental

26. Lack of focus	0 1 2 3 4 5
27. Gaps in memory	0 1 2 3 4 5
28. Memory loss of events	0 1 2 3 4 5

Relational

66. Guilt	0 1 2 3 4 5
67. Isolation	0 1 2 3 4 5
68. Disconnection	0 1 2 3 4 5

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29. Recurring dreams of events	0 1 2 3 4 5
30. Accident prone	0 1 2 3 4 5
31. Flashbacks /Intrusive imagery of events	0 1 2 3 4 5
32. Night terrors; abrupt waking with intense fear	0 1 2 3 4 5
33. Avoiding triggers associated with events	0 1 2 3 4 5
34. No sense of having a future	0 1 2 3 4 5
35. Loss of creativity	0 1 2 3 4 5
36. Feeling blocked	0 1 2 3 4 5
37. Not finishing what you start	0 1 2 3 4 5
38. Checking everything you do	0 1 2 3 4 5
39. Perfectionism	0 1 2 3 4 5

69. Disrupted relationships	0 1 2 3 4 5
70. A lot of drama in relationships	0 1 2 3 4 5
71. Alienation – believing no one understands	0 1 2 3 4 5
72. Fear of being alone	0 1 2 3 4 5
73. Fear of being with others	0 1 2 3 4 5
74. Feelings easily hurt by others	0 1 2 3 4 5
75. Difficulty getting close to others	0 1 2 3 4 5
76. Others feel you want to be too close	0 1 2 3 4 5

If you would like, please use the back of this sheet to elaborate on or clarify any of your answers.