Integrative Empowerment Group, PLLC

administration@integrativeempowerment.com | 734.945.6210

122 S. Main St.
Suite 200
Ann Arbor, MI 48104

"Liberation House"
560 S. Main St.
Ann Arbor, MI 48104

116 N. Fourth St.
Suite 100
Ann Arbor, MI 48104

"Saniyah Center"
2488 Golfside Dr.
Ypsilanti, MI 48198

New Client Packet

What to expect:

This intake packet was designed to appreciate the sensitive nature of your life experiences and presenting concerns. We request that you answer the questions as best you can and as close as possible to the date of your initial intake appointment. Time needed to complete this packet can vary greatly from person to person, but we recommend that you set aside a minimum of 1-1 ½ hours.

This packet is intended to be holistic and inclusive. The purpose of this packet is to help your therapist better understand your preferences, goals, needs, expectations, and concerns regarding therapy services at IEG. Some of these questions may bring up difficult or uncomfortable emotions. We encourage you to care for yourself while filling out this packet. Some effective examples include deep breathing, pacing yourself, pausing to take a break, self-soothing, and reaching out to supportive friends or emergency resources. **This may also include skipping entire sections as needed.**

Additional calming resources can be found on our website at: www.integrativeempowerment.com/resources

Emergency Resources

National Suicide Hotline	800.273.8255
Trans Life Line	877.565.8860
Ozone House Youth Crisis Line	734.662.2222
Crisis Text Line: Text "Hello" to:	741741
UofM Psychiatric Emergency Services (PES)	734.936.5900

Our mission is to make it easier for seekers to find knowledgeable and aware practitioners who understand their experiences. Integrative Empowerment Group (IEG) is a collective of therapists who share a vision of affirming diversity, empowering individual expression, and promoting mental, emotional and personal growth. Our practitioners understand that it is often not easy to reach out for help; especially if there is concern that people may not "get it" or understand your experiences. Our therapists are engaged in continuous consideration of how multiple oppressions (sexism, racism, heterosexism, classism, ableism, sizeism) in the current societal and historical context may be contributing to distress.

We make it our business to create a safe and affirming environment where our clients are free to truly be all of who they are without fear of being judged, pathologized, or otherwise feel misunderstood.

Feminist principles of collaboration, empowerment, and respect for multiple worldviews form the foundation of our approach.

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Additional Required Forms: available at www.integrativeempowerment.com/forms or from your therapist.

☐ Billing Form – Must be completed and submitted **BEFORE** first appointment.
- Submit by secure email to paperwork@integrativeempowerment.com or by fax to (734) 207-5326.

☐ Notice of Privacy Practices
- Review before first appointment.

☐ Notice of Receipt of Privacy Practices
- Review before first appointment and sign with therapist.

Informed Consent

Welcome! The following guidelines should answer most of your questions about our policies and procedures.

Consent to treatment: All clients are here voluntarily for their mental health care. The practice of therapy is not an exact science and no guarantees can be made as to the results of therapy.

Limits to Confidentiality: Confidentiality is an increasingly complex issue. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA), which went into effect on April 14, 2003. However, some situations, described in the bullets below, require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following situations:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your Clinical Record.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself.

- If I am being compensated for providing treatment to you as a result of your having filed a worker's compensation claim, I must, upon appropriate request, provide information necessary for utilization review purposes.

In addition, your insurance company, if you use one, requires a diagnosis be given in order to reimburse you for services rendered. They may also request additional information to authorize mental health services, process insurance claims and facilitate payments for mental health services, and to conduct retrospective reviews for quality assurance purposes. This information will be provided as needed (see the section on Client Records below). Although all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information data bank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without either your written authorization or a court order. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If you ask me to disclose parts of the Client Record to a third party to support a disability claim, a civil lawsuit, divorce, or similar legal or quasi-legal pursuit, I may strongly advise you against doing so because of the potential harm to our therapeutic relationship. If, as you read this, you have in mind using any part of the Clinical Record for an upcoming legal or quasi-legal pursuit, please inform me immediately so that, if necessary, I may help find you a clinician who can help you with those concerns.

There are four additional situations in which I am legally obligated to take actions. I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

- If you have expressed ideation, intent and plan to take your life and cannot guarantee your safety I will be required to get you connected to the nearest hospital for further assessment and to keep you safe. I may need to coordinate and communicate with the hospital and law enforcement in such cases.

- If I have reasonable cause to suspect child abuse or neglect, the law requires that I file a report with Child Protective Services. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to suspect the “criminal abuse” of an adult, I must report it to the police. Once such a report is filed, I may be required to provide additional information.

- If there is a threat of physical harm against a reasonably identifiable third person and I judge you to have the apparent intent and ability to carry out that threat in the foreseeable future, I may have to disclose information in order to take protective action. These actions may include notifying the potential victim (or, if the victim is a minor, their parents and the county Department of Social Services) contacting the police, and/or seeking hospitalization for you.

Supervision/Consultation: It is a continuing goal of Integrative Empowerment Group to provide the best possible service to clients. Accordingly, staff members seek, receive, and provide consultation and supervision to each other and outside sources whenever appropriate.

Record Keeping: You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records:

<u>One set constitutes your Clinical Record</u>. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You have a right to examine and/or receive a copy of your clinical record if you request it in writing, except in unusual circumstances, as follows:

- where disclosure would physically endanger you and/or others,

- when your record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person,

- where others have supplied information to me confidentially.

Because these are professional records, they can be misinterpreted and thus upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your Clinical Records, you have a formal right of review, which I will discuss with you upon request.

The second set of records is Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my assessment of those conversations, and how these conversations affect your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Client Rights: HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of Protected Health Information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which Protected Health Information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Weapons Policy: No weapons or firearms of any kind are permitted on the premises.

Substance Policy: If you arrive to therapy under the influence of any substance, prescribed or otherwise, that inhibits your ability to meaningfully engage in the therapeutic process, your therapist will end your session and you will be responsible for the late cancellation fee as disclosed in the Fee and Payment Agreement.

Emergency Accessibility: A 24-hour voicemail is available for your non-urgent messages. It is checked daily, Monday through Friday, and calls are typically returned by the next business day.

In the event of an emergency, call your local crisis hot line or emergency care facility (911). If you believe that you may require more extensive access to your therapist between sessions than what is described above, I am probably not the therapist for you. Please let me know and I will be happy to refer you to someone who provides this service. If you have questions about accessibility, please ask.

Termination: I expect that you will provide advance, face-to-face notice of your intention to terminate therapy. Doing so allows us to address the inevitable issues that come up when ending an important relationship.

If you cancel an appointment or fail to show up for an appointment and do not reschedule, I may not be able to hold that regular meeting time open for you. One month from the time of our last face-to-face contact, I will

email you asking if you would like to schedule another appointment. If I receive no reply to this email within two weeks of having sent it, I will take this as an indication that you want to end treatment. You are welcome to ask me for help in finding another therapist, and if you decide subsequently that you want to begin treatment again, I will be happy to see you if there is an available regular appointment time.

Either one of us may decide at some point that our continued working together is not adequately meeting your needs. I am ethically bound not to continue work that is harmful to you or that is less effective than what you might receive from another provider. If this situation arises (or any other unforeseen impediment to our working together, e.g., my becoming ill), I will try to provide as much advance notice as I can and will provide you with appropriate referrals.

By signing below, you agree that you have read this agreement and consent to its terms. It also serves as an acknowledgment that you have been offered the HIPAA Notice described above.

_____

Client Printed Name

_____ _____

Client Signature Date

_____

Witness Printed Name

_____ _____

Witness Signature Date

Fee and Payment Agreement

I,_____, hereby agree to pay Integrative Empowerment Group, PLLC a fee of $_____ per session (____ minutes) for counseling / psychotherapy services. My co-pay is $_____. I understand that payment of the agreed upon fee, or insurance co-payment, will be made following each appointment unless other arrangements are made. I further understand that I am responsible for paying all balances not paid by my insurance company, and I hereby agree to allow the release of basic information to a collection agency should I fail to pay any outstanding balances. I agree to pay any and all fees incurred by Integrative Empowerment Group, PLLC necessary to collect any unpaid balances after reasonable notification that I have an unpaid balance. *I understand these disclosures about fees, co-pays, and collections.* _____

If I am using insurance, I understand that it is my responsibility to verify coverage, learn about my in-network and out-of-network co-pay / co-insurance, and find out what limitations of coverage exist (e.g., deductible, session limits, pre-authorization requirements, etc.). I realize that some insurance companies contract out their mental health coverage to another company, e.g., Blue Cross Blue Shield may contract out their mental health coverage to Magellan. In such a case, I may be responsible for an out-of-network rate even though Integrative Empowerment Group, PLLC is in network for my main insurance. If for any reason my insurance company does not pay for a service, including undisclosed lapses in coverage, I will pay for that service. *I understand the expectation that I inform myself about my insurance coverage.* _____

I understand that I am required to give 24-hours' notice in order to cancel my counseling appointment. I hereby agree to pay the full fee (**$175**) for any appointments that I fail to cancel 24 hours in advance. An exception to the requirement to give 24-hours' notice will be made the first time it occurs. All subsequent missed appointments without 24-hours' notice or late cancellations will be charged the full fee regardless of the reason for the missed session or late cancellation. The missed appointment/late cancellation fee is due within seven days or at the next appointment, whichever is sooner. I understand that my insurance company will not pay for missed appointments or late cancellations. *I understand the missed appointment / late cancellation policy.* _____

By signing below, I agree that I have read this agreement and consent to its terms.

_____
Client Printed Name

_____ _____
Client Signature Date

_____
Witness Printed Name

_____ _____
Witness Signature Date

Contact and Demographic Information

Name: _____ Legal name (if different): _____

DOB: ____/____/____ Age: _____ Pronouns: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Okay to Call? ..... Yes ☐ No ☐ Preferred Time for Calls: _____

Text? ..... Yes ☐ No ☐ Leave a Message? ..... Yes ☐ No ☐ Cell only ☐

Email: _____ Okay to Email? ... Yes ☐ No ☐

Currently Employed? ..... Yes ☐ No ☐

1. _____ Position: _____

2. _____ Position: _____

Currently in School? ..... Yes ☐ No ☐

1. _____ Focus: _____

2. _____ Focus: _____

Military Experience? ..... Yes ☐ No ☐ Combat Experience? ..... Yes ☐ No ☐

Emergency Contact:

Name: _____ Relationship to Client: _____

Phone Number: _____ Email: _____

What did we miss? _____

_____

_____

_____

_____

For therapist use: _____

_____

_____

_____

Identity Chart	Identity	Do you question this Identity? Yes	Do you question this Identity? No	Is this a concern for Therapy? Yes	Is this a concern for Therapy? No
Example: Gender Identity	**Non-Binary**		✓	✓	
Race/Ethnicity		☐	☐	☐	☐
Gender Identity *(non-binary, cis, trans, woman, gender non-conforming, gender fluid, etc.)*		☐	☐	☐	☐
Sexual Identity *(gay, queer, asexual, bisexual, demi, kinky, pansexual, heterosexual, etc.)*		☐	☐	☐	☐
Relationship Status *(married, single, partnered, separated, widowed, etc.)*		☐	☐	☐	☐
Relationship Orientation *(monogamous, polyamorous, D/s, M/s, open, kinky, etc.)*		☐	☐	☐	☐
Dis/Ability *(physical, developmental, behavioral)*		☐	☐	☐	☐
Country of Origin		☐	☐	☐	☐
Spiritual/Religious Preference		☐	☐	☐	☐
Socioeconomic Background		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

What else would you like to share about your identity? _____

_____

_____

_____

_____

_____

For therapist use: _____

_____

_____

_____

Current Treatment Needs, Expectations, and Risk Assessment

What led you to seek treatment at this time? _____

How does this affect your overall functioning? _____

What are your treatment goals and expectations? _____

What are your expectations of your therapist? _____

If you've sought therapy for this concern in the past, what did you find effective and not effective? _____

What practical, emotional, cultural, and/or social barriers might affect your participation in treatment?
(E.g. time management, transportation, social stigma, etc.)

What other wellness services are you interested in at IEG or elsewhere regarding mental health treatment?
(E.g. group therapy, reiki, yoga workshops, EMDR, medication management, sex therapy, academic testing, etc.)

What else should we know regarding your current treatment needs? _____

--- *If you would like your therapist to consult with another provider or support, whether medical, legal, personal, or otherwise, please inform your therapist so they can help you complete the relevant authorization form.* ------

For therapist use: _____

This risk assessment covers topics that some folx may find sensitive or triggering. Please practice self-care while answering these questions and discuss any distressing reactions with your therapist. We encourage you to reference the emergency services on the cover page as needed. Some may find it helpful to skip ahead to the Resilience and Resources section after completing this assessment.

Do you ever engage in behaviors to harm or injure yourself? ..... Yes☐ No☐

If yes, how long ago did you feel like harming yourself? _____

Are you currently engaging in any self-injuring behaviors? ..... Yes☐ No☐

If yes, how? (i.e. cutting, picking, hair-pulling, etc.) _____

_____

If no, what prevents you from harming yourself now? _____

_____

Have you ever considered taking your own life? ..... Yes☐ No☐

If yes, when is the last time you considered this? _____

Do you currently have thoughts of suicide? ..... Yes☐ No☐

Have you attempted suicide in the past? ..... Yes☐ No☐

If yes, how? _____

If you currently have thoughts of suicide, what prevents you from acting on these thoughts? _____

_____

Have you ever tried to harm another/others? ..... Yes☐ No☐

If yes, how? _____

_____

How long did you feel like harming another/others? _____

Did you attempt to harm another/others? _____

What prevents you from harming another/others now? _____

_____

Do you feel unsafe in your home? ..... Yes☐ No☐

If yes, please explain: _____

_____

Do you feel afraid of your partner/family members? ..... Yes☐ No☐

If yes, please explain: _____

_____

Do you feel controlled or isolated? ..... Yes☐ No☐

If yes, by whom? _____

For therapist use: _____

_____

_____

_____

Mental, Emotional & Behavioral Functioning

Instructions

The organization of this symptom checklist is intended to gain a better understanding of current and lifelong experiences and is *not* meant to be used as a tool for self-diagnosis. If you have any questions or concerns, or are unsure how to answer, we invite you to discuss your experience with your therapist.

Please use this chart to indicate how frequently you experience the symptoms described below, ranging from: Never, Less than once per week, 1-3 times per week, 4-6 times per week, or Always/Daily. Please use the "Notes" section for any specific details you'd like to share, as demonstrated in the example.

Mood						
Experience	**Never**	**Less than 1x weekly**	**1-3x weekly**	**4-6x weekly**	**Always/ Daily**	**Notes:**
EXAMPLE: Racing Thoughts			✓			Current concern, I most often experience this at night
Little interest or pleasure in doing things	☐	☐	☐	☐	☐	
Feeling down, depressed, or hopeless	☐	☐	☐	☐	☐	
Feeling irritable, grouchy, or angry	☐	☐	☐	☐	☐	
Sleep disturbance (e.g. needing less sleep than usual but still having energy, difficulty falling or staying asleep, sleeping more than usual for you)	☐	☐	☐	☐	☐	
Starting a lot more projects than usual	☐	☐	☐	☐	☐	
Thoughts about death, self-harm, or suicide	☐	☐	☐	☐	☐	
Thoughts about harming or killing others	☐	☐	☐	☐	☐	
Feeling guilty	☐	☐	☐	☐	☐	
Bereavement, grief, feelings of loss	☐	☐	☐	☐	☐	

For therapist use: _____

Experience	Never	Less than 1x weekly	1-3x weekly	4-6x weekly	Always	Notes:
Low self-esteem	☐	☐	☐	☐	☐	
Feeling euphoric, energized, or highly optimistic	☐	☐	☐	☐	☐	
Racing thoughts	☐	☐	☐	☐	☐	
Talking more than usual, to the point that others notice	☐	☐	☐	☐	☐	
Difficulty concentrating	☐	☐	☐	☐	☐	
Engaging in risky behaviors	☐	☐	☐	☐	☐	
Low energy or fatigue	☐	☐	☐	☐	☐	
Difficulty making decisions	☐	☐	☐	☐	☐	
Changes in appetite or eating	☐	☐	☐	☐	☐	
Anxiety						
Feeling nervous, anxious, worried or on edge	☐	☐	☐	☐	☐	
Panic attacks	☐	☐	☐	☐	☐	
Avoiding situations that make you anxious	☐	☐	☐	☐	☐	
Unexplained aches and pains	☐	☐	☐	☐	☐	
Discomfort in social or performance situations	☐	☐	☐	☐	☐	
Fears of specific things (e.g. bugs, heights, enclosed spaces.)	☐	☐	☐	☐	☐	
Worrying about what others think of you	☐	☐	☐	☐	☐	

For therapist use: _____

Experience	Never	Less than 1x weekly	1-3x weekly	4-6x weekly	Always	Notes:
Procrastination	☐	☐	☐	☐	☐	
Skin-picking	☐	☐	☐	☐	☐	
Hair-pulling	☐	☐	☐	☐	☐	
Neurodiversity **The variation of the unique functioning of human brains and minds**						
Hearing and/or seeing things that other people cannot	☐	☐	☐	☐	☐	
Trouble explaining yourself to others	☐	☐	☐	☐	☐	
Easily distracted	☐	☐	☐	☐	☐	
Problems understanding what others tell you (not due to physical ability or language barrier)	☐	☐	☐	☐	☐	
Difficulty with transitions	☐	☐	☐	☐	☐	
Learning challenges	☐	☐	☐	☐	☐	
Doing things very slowly to make sure they are correct	☐	☐	☐	☐	☐	
Seeking reassurance from others	☐	☐	☐	☐	☐	
Needing cleanliness or order	☐	☐	☐	☐	☐	
Hyper-focus on interests or activities at the expense of everything else	☐	☐	☐	☐	☐	
Difficulty figuring out what others expect of you	☐	☐	☐	☐	☐	
Feeling driven to perform certain behaviors or mental acts repeatedly	☐	☐	☐	☐	☐	
Difficulty organizing tasks or activities	☐	☐	☐	☐	☐	

For therapist use: _____

_____

_____

_____

Experience	Never	Less than 1x weekly	1-3x weekly	4-6x weekly	Always	Notes:
Feeling easily overwhelmed by sensory input	☐	☐	☐	☐	☐	
Unpleasant thoughts, urges, or images that repeatedly enter your mind	☐	☐	☐	☐	☐	
Difficulty interpreting social cues	☐	☐	☐	☐	☐	
Repetitive behavioral movements (e.g. rocking, hand flapping)	☐	☐	☐	☐	☐	
Eating						
Restriction of food consumption	☐	☐	☐	☐	☐	
Binging	☐	☐	☐	☐	☐	
Purging	☐	☐	☐	☐	☐	

What else would you like to share about these aspects of your life? _____

_____

_____

_____

The next section is designed to assess additional the areas of your life that are satisfying and the areas of continued work and development. Please note the extent to which you are satisfied with different areas of your daily life and whether they're a concern for therapy by placing an ✓ in the relevant spaces below.

Area of Life	Highly Satisfied	Moderately Satisfied	Somewhat Satisfied	Dissatisfied	Is this a concern for Therapy? Yes	No
Example: Work/School		✓			✓	
Dress & Appearance	☐	☐	☐	☐	☐	☐
Eating & Appetite	☐	☐	☐	☐	☐	☐

For therapist use: _____

_____

_____

_____

Area of Life	Highly Satisfied	Moderately Satisfied	Somewhat Satisfied	Dissatisfied	Is this a concern for Therapy? Yes	No
Family Relationships	☐	☐	☐	☐	☐	☐
Finances	☐	☐	☐	☐	☐	☐
Friendships	☐	☐	☐	☐	☐	☐
Housing	☐	☐	☐	☐	☐	☐
Hygiene & Grooming	☐	☐	☐	☐	☐	☐
Intimate Partner Relationship/s	☐	☐	☐	☐	☐	☐
Physical Comfort (e.g., pain)	☐	☐	☐	☐	☐	☐
Recreation & Hobbies	☐	☐	☐	☐	☐	☐
Self-Image	☐	☐	☐	☐	☐	☐
Sexual Health & Functioning	☐	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐	☐
Social Media Usage	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐
Work & School	☐	☐	☐	☐	☐	☐

What else would you like to share about these aspects of your life? _____

_____

_____

_____

For therapist use: _____

_____

_____

_____

Sexual Functioning

Instructions

At IEG, we recognize that sexual health and functioning can be important for a sense of well-being. We also recognize that some, or all, of these questions could trigger feelings of discomfort, distress, or dysphoria, and that they might not resonate with you and your experiences in your body. Folx with multiple partners may find yes/no options limiting when answering questions. We encourage you to use narrative spaces to provide context and prompt more in-depth discussion with your therapist.

Please note that this is *not* a sexual assessment for sex therapy. If interested in sex therapy, please notify your therapist. These questions are meant to assess for any sexual functioning concerns that you may be experiencing. Feel free to inform your therapist if you believe that these questions are relevant to you and the work that you would like to focus on in therapy. If you believe these questions are not important in your therapeutic process, or if you feel too uncomfortable at this time, please feel free not to answer.

Have you ever been evaluated or received treatment for sexual functioning/health concerns? Yes ☐ No ☐

If yes, what was that experience like? _____

_____

_____

Are there any factors that may or may not support your exploration of sexuality? (e.g. religious/spiritual beliefs, culture, race, gender roles, current relationship dynamics, socioeconomic status, etc.) ..... Yes ☐ No ☐

If yes, what are they? _____

_____

_____

What is your level of comfort discussing your sexual health, sexuality, and sexual functioning? Are there any specific boundaries that we should be aware of? _____

_____

_____

Are there areas of your body or sexual functioning about which you have questions? ..... Yes ☐ No ☐

If yes, what are they? _____

_____

Do you feel uncomfortable asking for what you want and need sexually? ..... Yes ☐ No ☐

If yes, please explain: _____

_____

_____

For therapist use: _____

_____

_____

_____

Please read the following definitions and proceed by asking yourself: <u>Do I feel satisfied in these areas?</u>

Sexual stimulation/activity can be defined as "stimulus that leads to, enhances, or maintains sexual arousal and may lead to orgasm e.g. caressing, foreplay, masturbation, penetrative intercourse, kissing, massaging, sexual fantasy, sexting, or virtual/online sexual play."

Frequency of sexual stimulation/activity: ..... Yes ☐ No ☐ Partner Dependent ☐
Length of time spent engaging in sexual stimulation/activity:..... Yes ☐ No ☐ Partner Dependent ☐

Sexual arousal/desire can be defined as "feelings that include wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about sex. This may also include bodily responses to sexual arousal, e.g. wetness, sensitivity, flushed skin, etc."

Interest or desire for sex: ..... Yes ☐ No ☐ Partner Dependent ☐
Frequency of feeling aroused during sexual activity: ..... Yes ☐ No ☐ Partner Dependent ☐
Ease becoming aroused: ..... Yes ☐ No ☐ Partner Dependent ☐
Amount of lubrication experienced during arousal: ..... Yes ☐ No ☐ Partner Dependent ☐

Many factors in our lives can impact our levels of desire, arousal, and orgasm. Have you recently experienced any of the following stressors? (*please ✓ any that may apply*)

Depression	☐	Injuries	☐	Drugs	☐	Medical procedure	☐
Vulvar/vaginal discomfort/pain	☐	Medications	☐	Menopausal Symptoms	☐	Alcohol	☐
Pregnancy	☐	Ability to orgasm	☐	Childbirth	☐	Stress	☐
Fatigue	☐	Gender Dysphoria	☐	Relationship/s	☐	Erectile Functioning	☐
Orgasm Intensity	☐	Grief	☐	Moving	☐	Employment Changes	☐
Identity	☐	Other:	☐	Other:	☐	Other:	☐

What else would you like to share about your sexual health and functioning? _____

_____

_____

_____

For therapist use: _____

_____

_____

_____

Holistic Health and Medical History

As a holistic practice, we acknowledge that folx may address their wellness needs in a variety of different ways that may include Mind, Body, and/or Spirit. Please let us know what we missed and feel free to skip any question that may not be relevant to your experience and/or identity.

Have you experienced any of the following medical conditions in your lifetime?

	Current	Past
Allergies	☐	☐
Asthma	☐	☐
Auto-Immune	☐	☐
Chronic Pain	☐	☐
Diabetes	☐	☐
Dizziness / Fainting	☐	☐
Surgery	☐	☐
Headaches	☐	☐
Head Injuries	☐	☐
Hearing Problems	☐	☐
Infertility	☐	☐
Miscarriage	☐	☐

	Current	Past
Numbness	☐	☐
Seizure	☐	☐
Serious Accident	☐	☐
Sexually Transmitted Infection	☐	☐
Sleep Disorder	☐	☐
Stomach Aches	☐	☐
Thyroid Disease	☐	☐
Urination Difficulties	☐	☐
Vision Problems	☐	☐
Other:	☐	☐
Other:	☐	☐
Other:	☐	☐

Please list your **current** medication and non-prescription (over the counter) medications below:

Current Medication	What do you use it for?	When did you begin taking it?	Strength and Dosage	Prescribing Physician	Side effects Yes	Side effects No
EXAMPLE	**Arthritis**	**December 2017**	**50mg 1xday**	**Dr. Smith**		✓
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

For therapist use: _____

Please list your **past** medications and non-prescription (over the counter) medications below:

Previous Medication	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Was it effective? Yes	No
EXAMPLE	**Anxiety**	**10 months**	**Spring 2016**	**Symptoms subsided**	✓	
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Did you inform your prescribing medical provider when medications were stopped?..... Yes☐ No☐

Please describe any experienced side effects from prescribed medication, past or current: _____

_____

_____

Please list any allergies to medications: _____

_____

Comments on medical conditions and medications: _____

_____

_____

Who referred you to IEG? _____

Would you like your therapist to be able to communicate with your primary care doctor or any other prescribing practitioners? ..... Yes☐ No☐

If yes, please list their names here: _____

_____

_____

Notify your therapist to secure the necessary forms for each practitioner with whom you'd like to coordinate care.

For therapist use: _____

_____

_____

_____

Healing Modalities

Please ✓ any current/past practices that you engage/d in to improve your physical, mental, or spiritual health.

	Current	Past		Current	Past
Acupuncture	☐	☐	Hypnosis	☐	☐
Ayurvedic Medicine	☐	☐	Massage	☐	☐
Body Movement Therapies	☐	☐	Meditation	☐	☐
Chinese Medicine	☐	☐	Naturopathy	☐	☐
Chiropractic/Osteopathic Medicine	☐	☐	Nutritional Healing	☐	☐
Cupping	☐	☐	Physical Therapy	☐	☐
Dietary Supplements	☐	☐	Qigong	☐	☐
Electromagnetic Therapy	☐	☐	Reiki	☐	☐
Herbal Medicine	☐	☐	Tai Chi	☐	☐
Homeopathy	☐	☐	Yoga	☐	☐

What did we miss? _____

_____

What type of remedies are you currently taking? _____

_____

_____

Health Beliefs and Spirituality

How have your beliefs, if any, influenced how you take care of your physical, mental, and emotional health?

_____

_____

Do you feel that your spiritual health is affecting your physical health? ..... Yes ☐ No ☐

If yes, please explain: _____

_____

Does your spirituality impact your health care decisions? ..... Yes ☐ No ☐

If yes, please explain: _____

_____

For therapist use: _____

_____

_____

_____

In what ways (if any) do you engage in ritual for healing purposes? (e.g. prayer, shamanic healing, sacred body movements) _____

_____

Is there any certain way that you'd like for your therapist to consider your spirituality in relation to your mental health care? _____

_____

Is there anything else you'd like to share about the role of religion, spirituality, and/or ritual in your healing process? _____

_____

_____

Mental Health Treatment History

Have you ever received a mental health diagnosis? ..... Yes ☐ No ☐

If yes, please list here: _____

_____

Please use the chart below to document your history of treatment, including individual, family, and group therapy, psychiatric hospitalization, drug/alcohol treatment, self-help groups, support groups, etc.

Type of Treatment	When?	Provider/Program	Reason for Treatment	Was it effective? Yes	No
Self-help	**2014-current**	**Alcoholic Anonymous**	**Issues with alcohol use**	✓	
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Additional thoughts about your treatment history? _____

_____

_____

For therapist use: _____

_____

_____

_____

Substance Use History

Substance	Current Use (last 6 months)				Past Use			
	Yes	No	Frequency	Amount	Yes	No	Frequency	Amount
Alcohol	☐	☐			☐	☐		
Caffeine	☐	☐			☐	☐		
Cannabis	☐	☐			☐	☐		
Cocaine/Crack	☐	☐			☐	☐		
Hallucinogens	☐	☐			☐	☐		
Heroin	☐	☐			☐	☐		
Inhalants	☐	☐			☐	☐		
MDMA	☐	☐			☐	☐		
Methamphetamines	☐	☐			☐	☐		
Opiods	☐	☐			☐	☐		
PCP/LSD	☐	☐			☐	☐		
Steroids	☐	☐			☐	☐		
Tobacco	☐	☐			☐	☐		
Tranquilizers	☐	☐			☐	☐		

Family Mental Health History

Family Mental Health	Which family members experienced the following? Did they seek treatment?
ADD/ADHD	
Anger/Abuse	
Anxiety / Panic Attacks	
Bipolar Disorder	
Depression	
Disordered Eating	
Obsessive-Compulsive	
PTSD / Trauma	
Schizophrenia	
Sexual Abuse	
Substance Use	

Additional thoughts about and substance use or family history? _____

_____

_____

For therapist use: _____

_____

_____

_____

Adverse Life Experiences

The following section contains questions of a sensitive nature to help us understand how some distressing experiences may have affected you. **As feminist practitioners, we acknowledge that many adverse life experiences are a result of systems of oppression and discrimination.** Some folx might experience these as difficult or distressing to answer. Please pace yourself, be gentle, and tend to your needs as you fill this out. You also have the option to skip this section and talk about it with your therapist in person.

Instructions

Please ✓ the box if you have experienced any of the following in adulthood and/or childhood.

	Adult	Child		Adult	Child
Crime victim	☐	☐	Natural disaster	☐	☐
Divorce	☐	☐	Neglect	☐	☐
Emotional/verbal abuse	☐	☐	Parent illness	☐	☐
Exposure to large-scale conflict *(e.g. military, political and social unrest)*	☐	☐	Physical abuse	☐	☐
Financial challenges	☐	☐	Physical assault	☐	☐
Harassment / discrimination	☐	☐	Police harm or harassment	☐	☐
Houselessness	☐	☐	Separation from caregiver *(e.g. foster care, removal from home, loss)*	☐	☐
Identity-based harm	☐	☐	Serious accident *(car, plane, bike, fall down stairs)*	☐	☐
Immigration / citizenship challenges	☐	☐	Sexual abuse	☐	☐
Intimate partner abuse *(e.g. emotional, mental physical, sexual, financial)*	☐	☐	Sexual assault	☐	☐
Isolation *(e.g. financial, physical, or social)*	☐	☐	Sexual coercion	☐	☐
Jail / Incarceration	☐	☐	Torture	☐	☐
Life-threatening illness or injury	☐	☐	Harm in the home	☐	☐
Loss of a loved one	☐	☐	Other:	☐	☐

What would you like to share about any of these experiences? _____

_____

_____

_____

_____

_____

For therapist use: _____

_____

_____

_____

After traumatic life events, people can be affected in certain ways. Please ✓ the box if you have experienced any of the following in the **past month**:

Difficulty concentrating	☐	Intrusive, distressing thoughts or memories	☐
Feeling disconnected from others	☐	Irritability, angry outbursts, aggressive action	☐
Feeling jumpy or easily startled	☐	Nightmares	☐
Feeling super-alert, watchful, or on guard	☐	Strong negative feelings (fear, guilt, shame, anger)	☐
Flashbacks	☐	Trouble experiencing pleasant emotions	☐
Intense distress when reminded of event(s)	☐	Trouble falling or staying asleep	☐

What would you like to share about any of these experiences? _____

_____

_____

_____

_____

Emergency Resources

National Suicide Hotline	800.273.8255
Trans Life Line	877.565.8860
Ozone House Youth Crisis Line	734.662.2222
Crisis Text Line: Text “Hello” to:	741741
UofM Psychiatric Emergency Services (PES)	734.936.5900

Resilience and Resources

Resilience is the ability and attitude to adapt, cope, and thrive through difficulties, hardship, and adversity. While resilience can partly be an innate characteristic, it is also a skill that can be taught, learned, and practiced. The more resilient we are, the more likely we're able to deal effectively with negative life situations. You've survived 100% of bad days so far. Use this page to describe how you got through it all.

I demonstrate the following resilient characteristics and strengths (✓ all that apply):

Patience	☐	Determination	☐	Work ethic	☐	Flexibility	☐
Self-awareness	☐	Ability to reflect	☐	Gratitude	☐	Acceptance	☐
Asks for help	☐	Empathy	☐	Understanding	☐	Calm under stress	☐
Self-reliance	☐	Self-advocacy	☐	Optimism	☐	Boundaries	☐
Social supports	☐	Creativity	☐	Humor	☐	Makes meaning	☐
Self-control	☐	Discipline	☐	Courage	☐	Faith/Spirituality	☐
Altruism	☐	Self-growth	☐	Self-care	☐	Other:	☐

I practice the following resilient behaviors and activities (✓ all that apply):

Journaling	☐	Bodily movement	☐	Hydration	☐
Sleep	☐	Nutrition	☐	Going to therapy	☐
Talking with loved ones	☐	Self-help resources	☐	Connection with nature	☐
Gardening	☐	Cleaning	☐	Cooking	☐
Volunteering	☐	Relaxing hobbies	☐	Dancing	☐
Creation	☐	Art	☐	Religious/Spiritual practice	☐
Sex	☐	Yoga	☐	Massage	☐
Reading	☐	Vacation/Travel	☐	Connection with others	☐
Spending time with pets	☐	Watching movies/tv	☐	Community engagement	☐
Music	☐	Other:	☐	Other:	☐

How does my environment affect my capacity to cope? _____

_____

_____

For therapist use: _____

_____

_____

_____

How did I observe others' resilience during hard times when growing up? _____

_____

_____

What are at least five of the most important values to me? _____

_____

_____

How do I self-soothe my senses when feeling distressed? _____

_____

Things I enjoy:

- Seeing / Watching: _____
- Listening to / Hearing: _____
- Tasting: _____
- Smelling: _____
- Feeling / Touching: _____

If a friend were to share similar struggles as me, how might I respond to them? _____

_____

_____

Who do I want to be when looking into the future? _____

_____

_____

The Resilience and Resources section is designed as a therapeutic tool for your treatment.

We encourage you to take photos or make copies of these pages for your reference.

"…and that visibility which makes us most vulnerable is that which also is the source of our greatest strength." – Audre Lorde

For therapist use: _____

_____

_____

__

_____

_

Integrative Empowerment Group, PLLC

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Integrative Empowerment Group, PLLC to use and/or disclose my protected health information as described below to

(name and address of recipient)_____

_____

for the following purposes (client initials next to all that apply):

_____ Coordination of Care
_____ Continuity of Care
_____ Involvement of Support Person in Therapy
_____ Other (specify): _____

I understand that:

1. **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3. I may revoke this authorization at any time by notifying Integrative Empowerment Group, PLLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4. Integrative Empowerment Group, PLLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed (client initial):

_____ Assessment
_____ Diagnosis
_____ Psychological Evaluation
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Participation in Treatment
_____ Testing Information
_____ Continuing Care Plan
_____ Progress in Treatment
_____ History
_____ Billing Records
Other: _____
_____
_____

In addition, I authorize the release of the following information as a part of my clinical record (initial if applicable):

_____ HIV/AIDS infection _____ Drug/Alcohol abuse _____ Genetic Testing

Expiration:
This authorization will expire 180 days from the date of signing or **(insert date)** _____.

_____
Client Name

_____
Legal Name

_____
Signature of Client or Legal Representative

_____
Date

_____
Printed Name of Client's Representative (*if applicable*)

Relationship to Client (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____
Signature of Witness

_____
Date