# Integrative Empowerment Group, PLLC

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Ann Arbor, MI 48104

"Liberation House"
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"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 forms are available on our website www.integrativeempowerment.com/forms or from your therapist.

**Required Forms:**

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

**Supplemental Questionnaires:** Please complete any optional questionnaires that feel relevant to your care.

- ☐ Sexual Functioning
- ☐ Holistic and Spiritual Health
- ☐ Adverse Life Experiences

# 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**<br>**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: _____

_____

_____

_____

# Health and Medical History

Please indicate any current or past medical concerns below:

| | Current | Past | | Current | Past |
|---|---|---|---|---|---|
| Allergies | ☐ | ☐ | Numbness | ☐ | ☐ |
| Asthma | ☐ | ☐ | Seizure | ☐ | ☐ |
| Auto-Immune | ☐ | ☐ | Serious Accident | ☐ | ☐ |
| Chronic Pain | ☐ | ☐ | Sexually Transmitted Infection | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Sleep Disorder | ☐ | ☐ |
| Dizziness / Fainting | ☐ | ☐ | Stomach Aches | ☐ | ☐ |
| Surgery | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Headaches | ☐ | ☐ | Urination Difficulties | ☐ | ☐ |
| Head Injuries | ☐ | ☐ | Vision Problems | ☐ | ☐ |
| Hearing Problems | ☐ | ☐ | Other: | ☐ | ☐ |
| Infertility | ☐ | ☐ | Other: | ☐ | ☐ |
| Miscarriage | ☐ | ☐ | 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.***

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

If yes, please list here: _____

_____

For therapist use: _____

_____

_____

_____

## Treatment History

*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** | ✓ | |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

## Substance Use History

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

For therapist use: _____

## 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 your Treatment History, Substance Use History, and/or Family History? _____

Is there anything we missed regarding your Health and Medical History? _____

For therapist use: _____

# 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**