

# Brooke G. Dooley, LPC

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## Counseling Inventory

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Who referred you? \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Relational status: \_\_\_\_\_ Separated \_\_\_\_\_ Committed couple \_\_\_\_\_ Married

\_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Widowed

Highest level of education: \_\_\_\_\_

Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

If employed outside the house, who is your employer: \_\_\_\_\_

Do you have insurance? \_\_\_\_\_ If so, what plan? \_\_\_\_\_

Religion: \_\_\_\_\_ Email: \_\_\_\_\_

Is it okay if I contact you at the above Email address if needed? Yes No

I send out a monthly e-zine with helpful tips about creating healthy relationships, strategies for combating stress and new groups or services I will be offering in my practice. Initial here if you would like to receive this e-zine \_\_\_\_\_

Emergency contact person:

\_\_\_\_\_

Name

\_\_\_\_\_

Phone number

\_\_\_\_\_

Relationship to you

## Life change checklist

Rate each event below using the following scale (add written notes if necessary):

- |   |  |
|---|--|
| 0 | Has not occurred in the past few years         |
| 1 | Not stressful                                  |
| 2 | Mildly stressful                               |
| 3 | Stressful, though manageable                   |
| 4 | Very stressful, need support                   |
| 5 | Extremely stressful, need immediate assistance |

### Personal

- \_\_\_ Death of a close friend or family member
- \_\_\_ Personal injury, illness, or hospitalization
- \_\_\_ Pregnancy (or pregnancy of partner)
- \_\_\_ Loss of self confidence
- \_\_\_ Outstanding achievement (graduation, promotion, etc.)
- \_\_\_ Change in eating habits
- \_\_\_ Change in sexual activity
- \_\_\_ Suicidal thoughts
- \_\_\_ Change in religious belief and practice
- \_\_\_ Change in recreational time/activity
- \_\_\_ Trouble with the legal system
- \_\_\_ Miscarriage
- \_\_\_ Problems with addiction
- \_\_\_ Other \_\_\_\_\_

### Relationship

- \_\_\_ New significant relationship
- \_\_\_ New marriage or committed relationship
- \_\_\_ Change in a significant relationship, including with family members
- \_\_\_ Disagreements over money
- \_\_\_ Increased emotional distance
- \_\_\_ Lack of communication
- \_\_\_ Partner beginning or stopping work or school
- \_\_\_ Distress over sexual activity
- \_\_\_ Problems with another's use of alcohol, drugs, or gambling
- \_\_\_ Other \_\_\_\_\_

### Household/community

- \_\_\_ Family member left home or in the process of leaving
- \_\_\_ Gain of a new member (birth, parents moving in, adoption)
- \_\_\_ Partner at home more or less than before
- \_\_\_ Retirement of partner
- \_\_\_ Injury, illness or disability of a partner
- \_\_\_ Change of residence
- \_\_\_ Change in health/attitude/behavior of a member of the household
- \_\_\_ Aggression/hostility/anger/yelling in the house
- \_\_\_ Difficulty with the children
- \_\_\_ Other \_\_\_\_\_

**Work**

- New job, or new line of work
- Beginning to think about getting a job
- Quit a job
- Fired from a job
- Retired
- Laid off
- Less job security
- Promotion
- Demotion
- Trouble with work associates
- Change in hours, conditions, travel, etc.
- Other \_\_\_\_\_

**Financial**

- Changes in financial status
- Major mortgage or loan taken out
- Tension between partners or family members on the use of money
- Other \_\_\_\_\_

**Emotion/symptom checklist**

**Check those symptoms or emotions that you are most concerned about within yourself:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> stress        | <input type="checkbox"/> cynical attitudes   | <input type="checkbox"/> despair              |
| <input type="checkbox"/> anxiety       | <input type="checkbox"/> jealousy            | <input type="checkbox"/> rage                 |
| <input type="checkbox"/> depression    | <input type="checkbox"/> exhilaration        | <input type="checkbox"/> hatred               |
| <input type="checkbox"/> anger         | <input type="checkbox"/> fatigue             | <input type="checkbox"/> suicidal thoughts    |
| <input type="checkbox"/> guilt         | <input type="checkbox"/> nausea              | <input type="checkbox"/> negative attitude    |
| <input type="checkbox"/> fear          | <input type="checkbox"/> shakiness           | <input type="checkbox"/> poor self esteem     |
| <input type="checkbox"/> resentment    | <input type="checkbox"/> loss of appetite    | <input type="checkbox"/> lack of confidence   |
| <input type="checkbox"/> bad moods     | <input type="checkbox"/> constipation        | <input type="checkbox"/> critical thoughts    |
| <input type="checkbox"/> pessimism     | <input type="checkbox"/> worry               | <input type="checkbox"/> shy with people      |
| <input type="checkbox"/> inferiority   | <input type="checkbox"/> can't keep a job    | <input type="checkbox"/> can't make decisions |
| <input type="checkbox"/> loneliness    | <input type="checkbox"/> grief               | <input type="checkbox"/> shame                |
| <input type="checkbox"/> perfectionism | <input type="checkbox"/> compulsive behavior | <input type="checkbox"/> abandonment          |

### **General questions**

1. How much sleep do you get on the average night?
2. How much do you exercise?
3. Please describe your diet and eating habits. Do you crave sugar and carbs?
4. How much recreation and relaxation do you get?
5. How do you relax?
6. Do you feel overweight, underweight or neither?
7. What is your concept of your body?
8. Please list any medications you take regularly and note for what reason you take them (if you've ever taken medication for a mental health concern, please include that information).

9. Do you have physical symptoms that seem related to stress or anxiety?
  
10. Please list any major surgeries you've had and when they occurred.
  
11. Have you ever been in counseling or psychotherapy before or hospitalized for anything related to mental health? May I contact that therapist?
  
12. How much time do you spend with close friends?
  
13. Do you have people upon whom you can call for support? Who are they?
  
14. Who in your life knows you the best?
  
15. Are you satisfied with the amount of physical affection you receive?
  
16. Do you have any concerns about your sexual health or life?
  
17. What recent losses have you experienced?
  
18. What did your early religious training (if any) teach you about life?

19. What religious training, if any, have you rejected?

20. What gives meaning to your life?

21. Toward what goals would you like to work toward in counseling?

22. What strengths do you have that will assist you in moving toward these goals?

23. What are your limitations in moving toward these goals?

24. What is your consumption of:

alcohol \_\_\_\_\_

tobacco \_\_\_\_\_

caffeine \_\_\_\_\_

other drugs \_\_\_\_\_

Anything else you would like me to know about yourself?