Name_____

This information will help me help you. Please fill out as much of the form as feels relevant to you.

What kind of support system do you have?

Family____ Friends____ Relative____ Other_____

What do you enjoy doing? What do you do that makes you feel good?

What is your occupation?_____

Do you enjoy your work? Yes____ No___ Describe why or why not:

What are your eating habits like?

Typical Breakfast_____

Typical Lunch_____

Typical Dinner_____

Typical Snacks_____

Do you have a spiritual practice? Yes____ No____
What is it?

Have you ever been, or are you presently in counseling or psychotherapy?

Yes____ No____ Other therapeutic work____

Please describe why you went and your experience:

Hove you experienced any anxiety or depression lately? If yes, please describe.

Anxiety____ Depression____ Mixed____

Briefly describe your childhood, particularly in relationship to your family of origin:

Briefly describe your present living situation. What is your home life like? Do you live with anyone? Do you have children?

Marital status:
Single____ Married____ Committed Relationship ____
Divorced____ Remarried____ Spouses/Partner's Name_____

If divorced, when did you get divorced?_____

How was the process?_____

If remarried, when did you get remarried?_____

Do you have a blended family? Yes____ No____

How many children? Yours____ Spouses____ Together____

Do you smoke tobacco? Yes____ No____ Cigarette, Cigar, Pipe
How many per day:_____
Did you ever smoke tobacco? Yes____ No____
When did you quit:_____ How much did you smoke:_____

How much alcohol do you drink, if any? None____
___beers/day ____glasses of wine/day ____drinks/day

Do you use recreational drugs? Yes____ No____
If yes, what do you use? How often?

Have you ever had a problem with eating or an eating disorder?

Yes____ No____ Anorexia, Bulimia, Binging, Overeating

Have you recently or in the past thought about suicide? Yes____When_____ No___

Have you ever attempted suicide? Yes____ No____
If your answer is yes to either of these questions, please describe what treatment you have had:

Intake Part 2 *Trauma Intake*

Have you experienced…

Experience	✓	**Age**	**Brief Description, if you wish.**
Physical Injuries (include concussions)			
Physical abuse			
Emotional abuse			
Sexual abuse or assault			
Experiences of breathing difficulty			
Relevant significant medical/dental experiences			
Motor Vehicle accidents			
Surgeries (medical and dental)			
Relational/ Developmental trauma			
Birth or prenatal trauma if known			
Natural disaster involvement			
War, Military			
Transgenerational/ Historic			
Other			

Is there anything else you would like me to know right now?