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Empowerment Therapies

CLIENT IN-TAKE FORM

INSTRUCTIONS: The following questionnaire provides vital info to guide your healing and is a catalyst to surface within you specific thoughts and feelings to prepare you for your healing journey. There are no right or wrong answers. Please be patient and answer each question with care and honesty.

Name:_____
Today's Date:_____ Date of Birth: _____
Address:_____
Home Phone: _____ Business Phone:_____
Cell Phone: _____

1. What are your Mother's and your Father's names? Are they alive or deceased? If deceased, what was the cause of death?

2. How was your relationship with your parents? Did you feel loved and nurtured by them? Ignored?

3. Do you have sisters and/or brothers? If yes, how many and what are their names? Are any deceased?

4. I was child no. ___ in a family of ____ children.

5. When you were born, was it a normal birth? If not, please explain:

6. Describe the personalities of your siblings and what it was like growing up in their presence. If you had no siblings, what was that experience like?

7. Did your family maintain secrets out of shame, blame or fear? Please explain:

8. Do you have children? If yes, please list their names. Please include all children deceased, miscarried, aborted and alive. If deceased, please list the cause of death.

9. If you have deceased siblings, children or parents, or a deceased spouse, have you ever felt their presence around you? If yes, how often:

10. What family members are you currently living with? How do get along with them?

11. LOW HIGH
My **physical** well being is < 1 2 3 4 5 6 7 8 9 10 >

My **emotional** well being is < 1 2 3 4 5 6 7 8 9 10 >

My **mental** well being is < 1 2 3 4 5 6 7 8 9 10 >

My **spiritual** well being is < 1 2 3 4 5 6 7 8 9 10 >

12. Do you meditate? _____ If yes, how often?

13. Do you have other spiritual practices (chanting, prayer, yoga, etc.)? _____ If yes, what are they?

14. Do you have a spiritual connection? (Example: God, Gaia, Buddha, Universe) _____ If yes, what name do you use to address this connection?

15. Have you ever experienced hypnosis with a trained professional?_____ If yes, what were the results of your experience?

16. Do you believe in past lives? _____ If yes, why:

17. Place a number in each of the following blanks.
On a scale of 0 to 10 with 10 being the highest, I am generally:
<0 1 2 3 4 5 6 7 8 9 10 >

Successful _____	Observing _____	Opinionated _____
Open-minded_____	Optimistic _____	Friendly _____
Fearful _____	Withdrawn _____	Happy _____
Loving _____	Sad _____	Pessimistic _____
Unloved _____	Calm _____	Resourceful _____
Creative _____	Worried _____	Compassionate _____
Impatient _____	Resentful _____	Angry _____
Controlling_____	Helpless _____	preoccupied _____
Blaming _____	Introspective _____	Overwhelmed _____
Depressed _____	Suicidal _____	Controlled _____

18. My happiest experience was:

19. The last time I felt sad was:

20. I ask for help when I need it. YES ____ NO ____ If no, why not?

21. I admit my mistakes & defeats without feeling ashamed or "less than." YES ____ NO ____ If no, why not?

22. I am open and honest; not afraid to let other people see my real self. YES ____ NO ____ If no, why not?

23. If I could change something about myself, I would change:

24. I observe the negative or critical thoughts I think about myself and I immediately change them to positive ones. YES ____ NO ____ If no, why not?

25. I have a healthy social life because I:

26. Do you have satisfying relationships with friends of both genders?

27. Do you have a primary love relationship: ____YES ____NO If yes, how well do you function in the relationship? Has the relationship always been satisfying? If no, why not?

28. A **personal goal** I would like to achieve is:

29. A **career goal** I would like to achieve is:

30. When I **think** about and **feel** who I am, I see myself as:

31. Other people see me as:

32. What do you do to manage stress?

33. What makes you feel guilty or ashamed?

34. What aspects of your life are most on your mind or of the most concern to you at this time?

35. What specific issues/problems do you want to work on at this time?

36. Does food satisfy your hunger?

37. What are your eating habits and drinking patterns?

38. Do you have any compulsions, or addictions of any kind? If yes, please explain:

39. How well do you sleep?

40. Are you rested most of the time and how would you rate your physical energy level?

41. Do you dream? If yes, do you remember your dreams?

42. Do you have repeating dreams? If yes, please explain:

43. What led you to schedule this appointment?

44. How have you felt since making the appointment?

45. Did you have an urge to cancel the appointment?

46. If you are sensitive to your personal energy, has there been any change in your aura, emotions, mind, temperament or language since making the appointment? If yes, please explain:

47. Please check all that apply:

I have experienced the following symptoms in the past 6 months:

Insomnia _____	Back Pain _____	PMS _____
Indigestion _____	Muscle/joint Pain ____	Headaches _____
Colds/Flu _____	Constipation _____	Diarrhea _____
Pneumonia _____	Menstrual Cramps ____	Poor Appetite_____
Chest Pain _____	Easy Bruising_____	Skin Problems _____
Fatigue _____	Weight Loss _____	Weight Gain _____
Confusion _____	Listlessness _____	Allergies _____
High/low blood pressure_____	Bladder/Kidney Infection _____	
Inability to relax _____	Other _____	

Comments:

48. Nutrition

I eat mostly: Vegetables ___ Dairy Products ____ Whole-Wheat Products _____
Meats _____ Fish _____ Fruits _____ Rice _____ White Bread _____
Other: _____

49. Medications I am presently taking now:

50. I have the following illness or disease(s):

51. Are you currently being treated by a physician? _____ If yes, for what condition and/or symptom(s)?

52. Are you currently seeing a therapist for any type of therapy? _____ If yes, what type?

53. Have you ever been in therapy? _____ If yes, why and how long?

54. Has a trained mental health professional ever told you that you have a mental disorder? If yes, what was the diagnosis?

OFFICE Use Only: Customizing Client's Session for Relaxation and Inner Processing

Client's focus and most predominant senses:

Visual	_____	Can picture things with the mind.
Auditory	_____	Remembers things through sound, such as music, laughter, crying and is easily directed by sounds.
Kinesthetic	_____	Experience life through feelings. Can sense things; intuitive.
Olfactory	_____	Associates certain memories or people with fragrances. Can be turned off by certain smells.
Gustatory	_____	Associate memories with food, or other tastes.