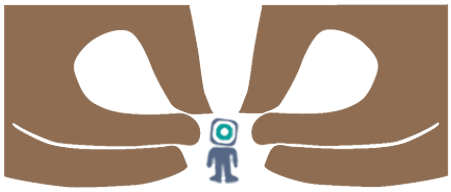

Mindfulness-Based Emotional Processing
Brainspotting and Hypnotherapy Clinic

New Client Intake Form

Name:

Last First Middle

Name of Parent or Guardian (if under 18)

Last First Middle

Birth Date: ____/_____/_____ Age: _____ Gender ☐ Male ☐ Female

Marital Status: ☐Never married ☐Domestic Partnership ☐Married
☐Divorced ☐Widowed

Please list names/ages of children if any:

Street Address:_____

City State Zip

Home Phone (____)_____ May we leave a message? ☐ Yes ☐ No

Cell/other (____)_____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we email you? ☐ Yes ☐ No

Referred by (if any):

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.? ☐ Yes ☐ No
If yes, whom did you see & what was your reason for seeking professional help?

_____

Are you currently taking any prescription medication ☐ Yes ☐ No
If yes, please list:

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No
If yes, list and provide dates:_____

_____

GENERAL & MENTAL HEALTH INFORMATION

How would you rate your current physical health?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits:
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing:

_____

Do you exercise regularly? ☐ Yes ☐ No
If yes, how many times per week do you exercise?_____

What types of exercise do you perform? _____

_____

Do you have any difficulties/concerns with appetite or eating? ☐ Yes ☐ No
If yes please describe:

_____

Do you currently experience overwhelming sadness, grief or depression?
☐ Yes ☐ No If yes, for how long?_____

Do you currently experience anxiety, panic attacks or phobias? ☐ Yes ☐ No
If yes, for how long?_____

Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If yes, please describe: _____

_____

Do you drink alcohol more than 3 times per week? ☐ Yes ☐ No
If yes, what type and how often?_____

How often do you engage in recreational drug use?
☐ Never ☐ Infrequently ☐ Monthly ☐ Weekly ☐ Daily

Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, for how long?_____
On a scale of 1-10, how would you rate your relationship?_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you.

	Check one	If yes, list family member(s)
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	

ADDITIONAL INFORMATION

Are you currently employed? ☐ Yes ☐ No

If yes, what is your job/profession?_____

Do you enjoy your work? ☐ Yes ☐ No

Is there anything stressful about your work?_____

_____

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, please describe:_____

_____

What do you consider to be some of your strengths and things you enjoy about yourself?

What do you consider to be some of your weaknesses or things you would like to change about yourself?

What would you like to accomplish with your time in therapy?