Trauma Therapy Solutions

CLIENT INTAKE FORM

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Gender / Preferred Pronouns _____

Ok to leave voicemail or text (please circle)

Have you received counselling / therapy before? ☐ Yes ☐ No

How did you learn about us? _____

I want (please circle): Clinical Supervision / Somatic Therapy (Somatic Experiencing) / NeuroAffective Touch

What brings you to counselling / therapy / supervision:

_____

_____

_____

What are your goals:

_____

_____

Are you on any medication? ☐ Yes ☐ No If yes, which ones _____

Please tick any relevant reasons for sessions and circle any specific issues:

☐ Anxiety	☐ Substance use issues	☐ Chronic Pain
☐ Depression	☐ Eating issues	☐ Chronic health condition (s)
☐ Suicidal ideation / self harm	☐ Addictions (any kind)	☐ Shock trauma
☐ Mental health diagnosis	☐ Relationship issues	☐ Physical assault
☐ PTSD / C-PTSD	☐ Domestic / family violence	☐ Physical injury / disability
☐ Grief / loss	☐ Family stress / separation	☐ Childhood emotional neglect
☐ Separation / divorce	☐ Childhood trauma	☐ Gender / identity / sexuality
☐ Traumatic event (s)	☐ Sexual assault / abuse	☐ Supervision for work / study
☐ Pre /perinatal trauma / adoption	☐ Self esteem / confidence	☐ Other:

Please add any additional information from the above boxes here: _____

Signature _____