Vibrant Transformation

Confidential Client Intake Form

Personal Information

Name:	Gender:	Date of Birth:	Age:	Today's Date:
Address:	City:	Province:	Postal Code:	
Home Phone #:	Other Phone #: ☐ Cel ☐ Work	Email:		
How would you like to receive appointment reminders? ☐ Phone ☐ Email May I email you about upcoming classes, workshops, and events? ☐ Yes ☐ No	How did you hear about our clinic?			

Contacts

Physician:	Physician's Phone #:	Physician:	Physician's Phone #:
Emergency Contact:	Emergency Contact #:	Relationship:	

Main Concern or Issue You'd Like to Work On

Primary Concern: ______________________________________ When did it begin? ________ ☐ Persistent ☐ Comes/goes Severity of Symptoms: 0 ├──────┼──────┤ 10 Severity is: ☐ Increasing ☐ Steady ☐ Decreasing What makes it better/worse? *(Activities, Relational Dynamics, Environments, Weather, etc)* List suspected factors in the onset / continuation of concern:	What would you like to achieve by receiving the session(s)? What is your goal or intention? What is a challenge or concern related to your goal/intention?

Your Health History

Describe Relevant Current and Past Symptoms, Medical History, and Medications

Describe Your Stressful Experiences

What aspects of your life contribute most to your stress? ___________________________________

Rate your current level of stress *(10 being the worse stress ever)*: 0 |――――――|――――――| 10

List three stressful events from your life:

① ____

____

② ____

____

③ ____

____

List any known birth stresses and complications *(Examples: stress or injury to pregnant mother, long birth, caesarian, use of forceps/vacuum, drugs, premature, incubator, etc)*:

Your Limiting Beliefs

"What I'm most afraid people will find out about me is _______________________________."

"What I'm most afraid people will think about me is _______________________________."

"A judgment/negative thought that I have had about myself is _______________________________."

"I believe I'll never be happy because I think I am _______________________________."

"I believe I'll never have enough because I think I am _______________________________."

"My most limiting thought that I have had about myself is _______________________________."

How has this limiting thought played out in your life?

How has it effected you?

What is possible if you didn't have this belief?

* Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

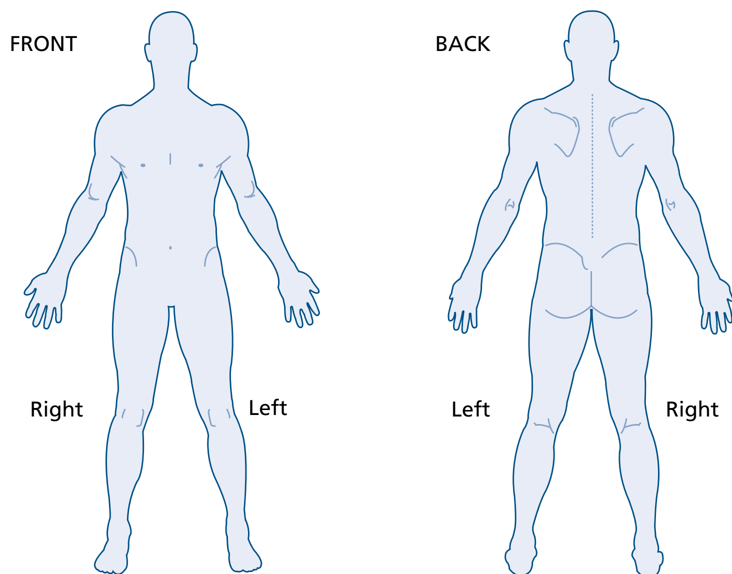
* Please mark the circle that best describes the level of stress for the below listings.

My family stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My relationship stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My work stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My financial stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My health stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
Other stress is _______________:	◯ None	◯ Minimal	◯ Moderate	◯ Severe

*** Please list areas of pain that best describe the level of discomfort on a scale of 1 to 10.**

1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.



COMMENTS:

Your Lifestyle

Diet *(Which foods do you consume most often? Do you have a special diet? (eg. Paleo, vegan, vegetarian, raw, etc)*:

____

____

How much water do you drink each day? ______________

Usage *(include frequency and amount)*:

☐ Alcohol ____________ ☐ Caffeine ____________ ☐ Tobacco ____________ ☐ Sugar ____________

☐ Recreational Drugs _______________ ☐ Pharmaceuticals ______________ ☐ Other ____________

Exercise *(List your typical physical activities along with frequency and duration of each activity)*:

____

____

Interests and Hobbies *(List what you enjoy most in life)*:

____

____

Do you have a religious or spiritual practice? What is it?

____

____

Relationship status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single
☐ In a supportive relationship ☐ Other: _______________

Number of children *(include ages)*: ____

Describe the emotional climate of your home: ____

Do you enjoy your work? ☐ Yes ☐ Sometimes ☐ No Do you take vacations? ☐ Yes ☐ No

Employer: _________________________ Occupation __________________________ ☐ Full-time ☐ Part-time

Exposure *(Are you frequently exposed to animals, toxins, or hazards at home, work, or during activities?)*:

____

Are you currently working with professional counselor? ☐ No ☐ Yes (If yes, what type? ____________)

Have you in the past? ☐ No ☐ Yes

Client Signature: ______________________ **Date:** ________________
(type name)

Guardian Signature: ______________________
(required if client is under 16 years of age)