WHOLE with Karen Gay

HMR®

Client Intake Form

Client Information

Full Name: _____

Date of Birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____ City: _____ Area Code: _____

E-mail: _____ Phone: _____

Primary Reason(s) For Seeking Services

☐ Anger Management	☐ Eating Disorder	☐ Addictive Behaviours	☐ Alcohol/Drugs
☐ Coping	☐ Anxiety	☐ Depression	☐ Fear/Phobias
☐ Mental Confusion	☐ Migraines ☐	☐ Health Struggles	☐ Chronic Pain
☐ Grief	☐ Trauma	☐ Post Traumatic Stress Disorder	
☐ Emotional Abuse	☐ Physical Abuse	☐ Sexual Abuse	☐ Marital Problems
☐ ACOA Issues	☐ Other Mental Health Concerns: _____		

_____

☐ Autoimmune Disorder - Please specify type:

☐ Lupus	☐ Fibromyalgia	☐ Arthritis	☐ Chronic Fatigue
☐ Crohn's	☐ IBS	☐ Colitis	☐ Eczema/Psoriasis
☐ Multiple Sclerosis	Other: _____		

_____

Relationship Status

□ Single □ Living Together □ Married □ Separated □ Divorce in Process □ Divorced
□ Partnership □ Widowed Total Marriages:
Current Relationship Assessment: □ Good □ Fair □ Poor □ Changing
Parental Relationship Status:
□ Parents legally married: □ Living □ Deceased □ Parents separated
□ Mother remarried: ____ Number of times □ Parents divorced: at your age
□ Father remarried: ____ Number of times
Special Circumstances: (e.g. raised by other than parents) _____

_____

Development

Are there special, unusual, or traumatic circumstances that affected your development:
□ NO
□ YES If yes, which type(s) of child abuse? □ Sexual □ Physical □ Verbal
The abuse was experienced as: □ victim □ perpetrator Other childhood issues: □ Neglect □ Hunger
□ Other: _____
Comments re: childhood development/domestic violence/abuse:

_____

_____

Social Relationships

Check how you generally get along with other people (check all which apply)
□ Affectionate □ Aggressive □ Avoidant □ Fight/argue often □ Follower
□ Friendly □ Leader □ Outgoing □ Shy/withdrawn □ Submissive
Other (specify): _____

_____

Spiritual/Religious/Cultural

How important to you are spiritual matters? □ Little □ Moderate □ Very Important
Are you affiliated with a spiritual or religious group? □ No □ Yes (describe) _____
Were you raised within a spiritual or religious group? □ No □ Yes (describe) _____
Would you like your spiritual/religious beliefs incorporated into the counseling? □ No □ Yes (elaborate)

_____

Was there “religious addiction” or excessive religious rigidity in your upbringing? □ No □Yes (describe)

_____

Are you experiencing any problems due to cultural or ethnic issues? □ NO □ YES (describe)

_____

Medical/Physical Health

Are you allergic to any medications or drugs? □ No □ Yes (describe)

Current/Prescribed Medications:	Dosage:	Dates:	Purpose:	Side-effects:
Over the counter medications:				

CURRENT HISTORY: Please check if there have been any recent changes in the following:

□ Sleep patterns □ Eating patterns □ Behaviour □ Energy Level □ Physical activity level
□ General disposition □ Weight □ Nervousness/tension
Describe changes in areas which you checked above:

Chemical Use History

Substance:	Method of Use & Amount	Frequency	Age of First Use	Age of Last Use	Used in Last 48 Hours: “YES”	Used in Last 48 Hours: “NO”	Used in Last 30 Days: “YES ”	Used in Last 30 Days: “NO”
Alcohol					☐	☐	☐	☐
Barbiturates					☐	☐	☐	☐
Benzo-diazepines: Xanax, Klonopin, Valium, Ativan					☐	☐	☐	☐
Cocaine/Crack					☐	☐	☐	☐
XTC/Ecstasy					☐	☐	☐	☐
Inhalants					☐	☐	☐	☐
Heroin/Morphine/Opiates					☐	☐	☐	☐
Marijuana					☐	☐	☐	☐
PCP/LSD/Mescaline					☐	☐	☐	☐
Caffeine					☐	☐	☐	☐
Nicotine					☐	☐	☐	☐
Over the counter meds:					☐	☐	☐	☐
Prescription meds:					☐	☐	☐	☐
Other drugs:					☐	☐	☐	☐

Chemical Use Questions (If Applicable)

Describe when and where you typically use substances: _____

_____

Describe any changes in your patterns: _____

Describe how your use has affected your family or friends (include their observations):

_____

Reasons for Use: □ Addicted □ Build confidence □ Escape □ Self-medication □ Social Anxiety □ Taste
□ Boredom □ Other: _____

When using a stimulant, do you "speed up" or "slow down/get sleepy"? _____

Have you ever been diagnosed with ADD or Bipolar Disorder? □ No □ Yes

How do you believe your substance use affects your life? _____

_____

Who or what has helped in stopping/limiting your use? _____

Does/has someone in your family (present/past) have (had) a problem with drugs or alcohol? □ No □ Yes
Describe the circumstances: _____

_____

Have you had withdrawal symptoms when trying to stop drugs/alcohol? □ No □ Yes
Describe your experience: _____

_____

Have you had adverse reactions or overdose to drugs & alcohol? (Describe)

_____

_____

Have drugs or alcohol created a problem for your job? □ No □ Yes (Describe)

_____

_____

Client Therapy History

EXPERIENCE	NO	YES	WHEN	PURPOSE	LOCATION	OUTCOME
Psychotherapy/ Counseling	☐	☐				
Psychiatric Treatment	☐	☐				
Drug/Alcohol Treatment	☐	☐				
Hospitalizations	☐	☐				
12 Step Groups	☐	☐				
Other self-help	☐	☐				
Other self-help	☐	☐				
Other self-help	☐	☐				

Family Significant Others History

EXPERIENCE	NO	YES	WHEN	PURPOSE	LOCATION	OUTCOME
Psychotherapy/ Counseling	☐	☐				
Psychiatric Treatment	☐	☐				
Drug/Alcohol Treatment	☐	☐				
Hospitalizations	☐	☐				
12 Step Groups	☐	☐				
Other self-help	☐	☐				
Other self-help	☐	☐				

Desired Change

Please check the behaviours/symptoms that you experience more than you would like:

☐ Aggression	☐ Distractibility	☐ Impulsivity	☐ Phobias/fears
☐ Alcohol Dependence	☐ Dizziness	☐ Irritability	☐ Sexual addiction
☐ Anger	☐ Drug dependence	☐ Judgment errors	☐ Sexual difficulties
☐ Antisocial behavior	☐ Eating disorder	☐ Loneliness	☐ Sick frequently
☐ Anxiety	☐ Elevated mood	☐ Memory impairment	☐ Sleeping problems
☐ Avoiding people	☐ Fatigue	☐ Mood shifts	☐ Speech problems
☐ Chest pain	☐ Gambling	☐ Negative self-talk	☐ Suicidal thoughts
☐ Co-dependancy	☐ Hallucinations	☐ Obsessive thoughts	☐ Thoughts disorganized
☐ Cyber addiction	☐ Heart palpitations	☐ Others before self	☐ Withdrawing
☐ Depression	☐ High blood pressure	☐ Panic attacks	☐ Worrying
☐ Disorientation	☐ Hopelessness	☐ People pleasing	☐ Sleeping problems
☐ Other			

Briefly discuss how the above symptoms impair your ability to function effectively:

Client Consent

I understand that I am about to experience a technique known as “Holographic Memory Resolution®.” I agree to undergo this practice by my own choice, recognizing that HMR does not constitute “medical” diagnosis, a medical practice or procedure. I understand that the stress/trauma resolution techniques employed do not supplant the need for psychiatric or therapeutic treatment of personality disorders, physiologically-based conditions and disorders, or primary illnesses such as chemical dependency; I recognize that the efficacy of this method may be influenced by the aforementioned conditions, particularly the use of or dependency upon benzodiazepines limiting my capacity to effectively apply or benefit from the effects of HMR.

I understand that, as a “body-centered, client-centered” therapy, HMR may enhance my access to previously forgotten or repressed memory encoded during moments of acute stress. I understand that there is a very limited risk of accessing subconscious memory data that will require more intensive therapeutic intervention or follow-up beyond the capacity of the facilitator, at which time I will be directed or referred to the appropriate therapeutic resources for resolution. I accept my own responsibility for the follow-up to these therapeutic recommendations.

It is my understanding that HMR functions by providing enhanced access to the data of memory, whether this data is historical, imagined, dreamed, or otherwise acquired. Accepting this “non-intrusive” procedure, I understand that what I experience with HMR is the product of my own perceptual processes and that the therapeutic data recorded is not a medical or legal record of historical events. Furthermore, I acknowledge that it is not the role, expertise, or authority of the HMR facilitator to verify, interpret, or explain the authenticity of these images, but merely to provide safety, support, and feedback for my own stress reduction and empowerment process.

Print Client’s Name: _____

Client Signature: _____

Date: _____

(Parent/Guardian Signature if Minor): _____

Karen Gay, MSC., HMR®, BCST® _____

Date: _____