

# CLIENT INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Physical Address \_\_\_\_\_

Mobile Phone number \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_

**\*\*Please answer the questions below and send the completed form back to me prior to our session.**

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How did you first learn/hear about the care i provide?

What specifically would you like help with?

How long have you experienced or been aware of this?

How will you know it's gone or is no longer something you are struggling with?

How would you like to feel?

Any surgeries, accidents, or near drowning? If yes, please give details.

Are you taking any medication or seeing a doctor or therapist? If yes, please explain.

What are your happiest memories, what brings you joy? Please list some examples.

What are the places where you feel at ease, happy or safe? Please list below.

What are the activities that you find interesting, enjoyable or engaging? Please list below.

Thank you!