
Somatic Experiencing Session Intake

Client Information

Name: _____ DOB: _____

Address: _____

Client's Telephone (cell): _____ (home): _____

(work): _____

Email: _____

Emergency Contact

Name: _____

Address: _____

Telephone Numbers: _____

Relationship to Client: _____

How did you hear about me? Who / what referred you?

What are your goals or intentions in seeking support?

Have you received other types of support for this?

Please describe in detail your current condition, your symptoms and their frequency. Note any time of day/night when it is worse, any patterns you notice around what may trigger it (stress, emotional upset, lack of sleep, eating certain foods, environments, exercise, family, relationships, etc.)

Please list any major accidents, surgeries, major injuries, intense relationships, or any especially difficult experiences you've had in your life. Please list approximate dates as well:

Please list medications, supplements, and other substances you are taking and what you're taking them for:

Do you smoke? Yes No. If yes, what kind, how much/month? _____

Do you experience any of the following?

- Yes No **Headaches** or migraines
- Yes No Back pain
- Yes No Jaw pain or clicking
- Yes No Vision issues
- Yes No Nightmares
- Yes No Digestive issues
- Yes No Difficulty hearing
- Yes No Do you grind your teeth at night
- Yes No Do you ever have trouble falling asleep

If you checked yes to any, please explain in the space below: (location, frequency)

and duration, etc.) _____

Are you currently undergoing stress or going through an emotionally strenuous period in your life? If so, what are you doing to manage it? __Yes __ No

How would you rate your current level of stress? (9 is the highest): 0 1 2 3 4 5 6 7 8 9

Have there been any losses or big changes recently in your life? (ie: living situation, work, family, or relationship) __Yes __ No

What brings you the most joy, ease, inspiration, or sense of belonging in your life?

Do you have any animal critter friends in your life? __Yes __ No _____

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Do you have any kind of mind/body practice? (yoga/meditation/martial arts/time in nature, etc.,)

What do you do for exercise?
