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Confidential Client Intake Form

The purpose of this questionnaire is to get a more complete picture of your current situation that would be helpful to our therapeutic relationship, without having to use a great deal of valuable therapy time. Please answer the questions as accurately as you can. You may email me or print your completed form prior to our first appointment.

Today's Date _____

Full Legal Name _____

Mailing Address _____

Phone Number 1 _____

- Preferred for communication
 You may leave a message

Email Address _____

- Preferred for communication

Phone Number 2 _____

- Preferred for communication
 You may leave a message

Date of Birth _____

Age _____

Gender _____

Sexual Preference _____

Partnership / Marital Status

Children

- No
 Yes

Names and Ages of Children

If yes, do they live with you:

- Full Time Part Time Do not live with me

Current Occupation and Status

Completed Level of Education

Emergency Contact Name and Relationship

Emergency Contact Phone Number

COUNSELING AND PSYCHOTHERAPY NEEDS

1. What are the challenges that bring you to therapy?

2. How long have you had these challenges?

3. List information for the past 3 counselors or mental health professionals you have seen, if applicable.

Counselor / Therapist Name	Date last seen	Duration of therapy	Satisfied or Dissatisfied?

4. Why are you interested in Somatic / Body-Oriented Psychotherapy?

5. What are your goals for counseling now?

HEALTH AND WELLNESS

6. Describe your physical and mental health history using the chart below.

	When?	Describe
Illness or Diagnosis		
Hospitalizations, Surgeries, or other Medical Procedures		
Drug, Alcohol or other Rehabilitation		
Allergies		
Other mental health information		
Other medical information		

7. List current medications, supplements, or herbs you take.

Name	Reason for taking	How long have you taken?

8. List any other health and wellness professionals or doctors you are currently seeing.

Practitioner Name	Date last seen	Reason for visits

9. Indicate your current or historical use of substances, either legal or illegal.

Substance	Currently Use?	Frequency of Use	Weekly Quantity	Length of Time Used
Caffeine				
Alcohol				
Marijuana				
Prescription Drugs				
Narcotics or Street Drugs				
Other				

LIFESTYLE AND ENVIRONMENT

10. Describe your current living situation.

11. Describe **BENEFICIAL** activities, resources, or relationships you are involved with.

12. Describe **DETRIMENTAL** activities, resources, or relationships you are involved with.

13. Rate your quality of life in the following areas, using the scale below.

	4 Excellent	3 Good	2 Fair	1 Poor
Marriage / Partnership			Nutrition and Eating	
Family			Sleep	
Friendships			Exercise	
Social Activity			Physical health	
Job / Career			Mobility	
Education / School			Energy level	
Financial			Sexuality	
Legal			Mood	
Environmental			Emotions	
Cultural			Thoughts	
Spiritual			Behaviors	

TRAUMA HISTORY

14. Circle Yes or No for any traumatic incidents you have experienced as an adult or child. Include approximate age(s) when each incident occurred.

	Yes	No	Age		Yes	No	Age
Physical assault / violation	Y	N		Natural disaster	Y	N	
Sexual assault / violation	Y	N		Victim of crime	Y	N	
Verbal or Emotional abuse	Y	N		Other (describe below)	Y	N	
Military combat	Y	N					
Accident or injury	Y	N					

VISUAL BODY REPRESENTATION (Optional)

The following exercise is optional and may be helpful information for body-oriented therapy.

Directions: Print this page and use pencils, crayons, markers or other materials to color and draw your current representation of how you experience and relate to your body. There is no right or wrong answer, and you can be creative in your personal representation. You may choose to complete this exercise at any point during therapy, though it is helpful near the beginning. We will talk about the personal meaning of your picture in session.

