CLIENT INTAKE QUESTIONNAIRE

FOR: "INDIVIDUAL HEALING APPROACHES" **Date:** _____

All information given on this questionnaire will be kept strictly confidential.

Please fill out the following form with your first thought. Extensive description will be discussed during the sessions.

REMEMBER THIS IS ACTUALLY THE BEGINNING OF FINDING THE ANSWERS TO YOUR CHALLENGE …SO TAKE IT SERIOUSLY… Sophia Kramer-Leto, Ph.D.

Name: _____ Date of Birth:_____ Sex: M F

Address: _____

_____

_____

Occupation :_____

Daytime Phone:(____) _____ Evening Phone:(____) _____

Cell Phone: (___)_____

E-mail: _____

Marital Status:_____ Name of Spouse or Partner:_____

Name& ages of Children: _____

1. List Three Favorite Colors: _____

2.. List Three Favorite Places: _____ _____ _____

3. On vacation, do you prefer relaxation or excitement? _____

4. List any fears or phobias: _____

5. Do you suffer any compulsive tendencies? _____

6. List any current health problems: _____

7. List any medications you are taking? : _____

8. Please list your three most important lifetime goals:

_____

_____

9. Please list your three past-times/hobbies: _____

_____

10. What is your current occupation? _____

11. Do you enjoy your work? _____

12. Please list things that you like to do but that you want to do better?

_____

13. If you could be, do, have or become anything, what would you wish for?

_____

14. Why are you seeking Therapy? _____

15. How did you hear about this office?

16. Are you currently suffering from any of the following? (Please check all that apply.)

__ nervousness __ poor health __ poor memory__ inability to relax __ cigarette smoking __ marital problems__ sleepless__ alcohol abuse __ recent divorce__ depression __ drug abuse __ war trauma__ sexual dysfunction__ compulsive overeating __ current illness __ nail biting

__ compulsive tendencies __ serious eating disorder __ teeth grinding __ codependency __ lack of energy__ nightmares __ inability to focus attention __ death of a loved me

__ childhood trauma __ abusive home situation __ lack of success__ fear of heights __ abusive work __ other__ poor self-esteem __ sexual abuse

17.One of the things I feel guilty of is:

_____

18. I am happiest when:

_____

19. I get so angry when:

_____

20. I am most saddened by:

_____

21. All my life:

_____

22. Ever since I was a child:

_____

23. One of the ways I could help myself but don't is:

_____

24. It is hard for me to admit:

_____

25. I am a person who:

_____

26. A mother should:

_____

27. A Father should:

_____

28. A true friend should:

_____

29. Please mention your most significant memory, experience or event from each of the following ages. Please also specify any events, which might have happened to your family members.

0-5: _____

6-10: _____

11-15: _____

16-20: _____

21-25: _____

26-30: _____

31-35: _____

36-40: _____

41-45: _____

46-50: _____

51-55: _____

56-60: _____

61-65: _____

66-100: _____

30. What would you like to start doing?_____

31. What would you like to stop doing? _____

32. What would you like to do more of? _____

33. What would you like to do less of? _____

34. What makes you laugh? _____

35. What makes you cry? _____

36. What makes you happy? _____

37. What makes you sad? _____

38. What makes you mad? _____

39. What makes you frightened? _____

40. What do you imagine yourself doing in the next 6 months?

_____

41. What do you see or imagine yourself doing in 3 years?

_____

42. What would have to change or be different for that to happen?

_____

43. What are your main beliefs and values?

_____

44. What are your main should, could, must and ought to's ? _____

45. What motivates you? _____

46. In one word describe your life: _____

47. In one word describe your problems:_____

48. One of the things I feel proud of is: _____

49. Do you observe any religious or meditative practices?_____

50. Do you believe in past lives? _____

51. Please explain any other negative conditions affecting you:

_____

52. Please list any additional needs or concerns:

_____

Neurolinguistic Learning Channel Profile:

Instructions: Please X off characteristics that relate to your behavior.

Visual:

1. Likes to keep written records [ ]
2. Typically reads billboards while driving or riding [ ]
3. Puts model together correctly using written directions [ ]
4. Follows written recipe easily when cooking [ ]
5. Writes on napkins in restaurants [ ]

6. Can put bicycle together from a mail order house using only written directions provided [ ]
7. Commits a zip code to memory by writing it [ ]
8. Uses visual images to remember names [ ]
9. A bookworm [ ]
10. Plans the upcoming week by making a list [ ]
11. Prefers written directions [ ]
12. Prefers to get a map and find own way in a strange city [ ]

Audio:

1. Prefers to have someone else read instructions when putting model together [ ]
2. Reviews for a test by reading notes aloud or by talking to others [ ]
3. Talks aloud while working out a math problem [ ]
4. Prefers listening to CD over reading a book [ ]
5. Commits zip code to memory by repeating it [ ]
6. Review for a test by writing a summary [ ]
7. Talks to self [ ]
8. Prefers oral directions [ ]
9. Stops at a service station for directions in a strange city [ ]
10. Keeps up with the news by listening to the radio [ ]
11. Able to concentrate deeply on what another is saying [ ]
12. Uses free time while talking with others [ ]

Kinesthetic:

1. Likes to build things [ ]
2. Uses sense of touch to put a model together [ ]
3. Can distinguish items by touch when blindfolded [ ]
4. Learns touch system rapidly when typing [ ]
5. Moves with the music [ ]
6. Doodles and draws on any available paper [ ]
7. An out of doors person [ ]
8. Moves easily coordinated [ ]
9. Spends large amount of time on crafts [ ]
10. Likes to feel texture of clothes and furniture [ ]
11. Prefers action activities [ ]
12. Finds it very easy to keep fit physically [ ]

Visual Number: [ ] Auditory Number [ ] Kinesthetic Number: [ ]

Stress Level Profile:

Instructions: Read each statement below & X the number that best represents yourself & your behavior at this time.

1 - not at all, 2 – slightly, 3 – moderately, 4 - very much

1. I often lose my appetite or eat when I am not hungry __ 1 __2 __3 __4
2. My decisions seem to be more impulsive than planned, I tend to feel unsure about my choices &often change my mind__ 1 __2 __3 __4
3. The muscles of my neck, back and stomach are often tense __ 1 __2 __3 __4
4. I have thoughts &feelings about my problems that run through my mind for much of the time __ 1 __2 __3 __4
5. I have a hard time sleeping, wake up often or feel tired..... __ 1 __2 __3 __4
6. I feel the urge to cry or get away from my problems__ 1 __2 __3 __4
7. I tend to let anger build up &then explosively release my temper in some aggressive way or destructive way __ 1 __2 __3 __4
8. I have nervous habits (tapping my fingers, shaking my leg, pulling my hair, scratching, wringing my hands &etc.) __ 1 __2 __3 __4
9. I often feel fatigued, even if not doing physical work __ 1 __2 __3 __4
10. I have problems with constipation, diarrhea, upset stomach __ 1 __2 __3 __4
11. I tend not to meet my expectations either because they are unrealistic or I have taken on more than I can handle __ 1 __2 __3 __4
12. I periodically loose my interest in sex __ 1 __2 __3 __4
13. My anger gets aroused easily __ 1 __2 __3 __4
14. I often have bad unhappy dreams or nightmares __ 1 __2 __3 __4
15. I tend to spend a great deal of time worrying about things __ 1 __2 __3 __4
16. My use of alcohol, coffee, smoking or drugs has increased __ 1 __2 __3 __4
17. I feel anxious, often without any reason that I can identify __ 1 __2 __3 __4
18. In conversation my speech is weak, rapid, broken, or tense __ 1 __2 __3 __4

Challenges Checklist:

Place the appropriate number on the lines below on a scale of 1 to 5 (#1 is the most important and # 5 is the least important). You may use one number more than once, for instance you may have three # 1 challenges. Mark the issues that apply to you.

__Need a job

__Worn out by job

__Cannot save money __long term __short term

__Cannot get ahead __Problems with co-workers or boss

__Dislike job __school

__Too much spare time__

__Bad habits_____

__Drug problems _____ Which drug?_____

__Drink too much. How much of what?_____

__Weight problems: Weight: _____Height: _____Desired Weight_____

__Eat too much: _sweets _junk foods _Other_____

__Not enough: exercise Get____min. per day/week
__Dissatisfied w/appearance . Why?_____
__Want to quit smoking___ smoke __ cigarettes per day
__Difficulty getting to sleep_____ Cannot stay asleep_____
__Poor memory_____
__Studying is dull____
__Poor concentration____
__Procrastinate a lot_____ Work _____ Personal_____
__Poor Organization____
__Would like to raise income Present income: $_____/yr.
Desired income: $_____/yr. What yr._____
__Desire a promotion____
__Want to change_ business _____ Jobs_____ Work too dull_____
__Afraid to take risks____ business _____ personal_____
__Blame others___
__Want to know my life mission_____
__Need more goals_____
__Lack of skills____
__Lack of motivation/ambition___ Trouble making decisions_____
__Trouble with children _____
__Trouble w/loved ones_____
__Quarreling at home _____
__No time to relax _____
__Need more fun _____
__Unwanted emotions _____
__Wanted emotions that are absent:_____
__Depression (How often?)_____
__Too pessimistic _____
__Fear/Phobia of_____
__Afraid of people _____
__Low self esteem _____
__Thought about suicide. Last time: _____(date)
__Fear of dying _____
__Too emotional _____
__Too nervous _____
__Guilt feelings _____
__Negative reaction to stress _____
__Difficulty relaxing _____
__Bad dreams _____
__Cannot express emotions (specify)_____
__Dislike people _____

__Frequent crying _____

__Different from others, how?_____

__Fear responsibility _____

__Quick to anger _____

__Too critical of others _____

__Violent _____

__Verbally abusive when angry _____

__Do not trust others ____

__Too sensitive ____

__Feel sad frequently _____

__Do not communicate _____

__Speech problems_____

__Public speaking : Fears_____ Lack of skill_____

__Poor vision: Wear glasses __Yes __No

__Hearing impairment_____

__Cannot get up mornings_____

__Get sick a lot____

__Lack of energy_____

__Blood pressure: High__ Low___

__Menopause difficulties_____

__Allergies to _____Symptoms_____

__Physical pain_____

__Spiritual problems_____

__Hard to meet people: business _____ personal_____

__Still grieving over_____

__Feel lonely_____

__Too shy_____

__Want a love relationship_____

__Desire more sex_____

__Unhappy marriage_____

__Divorce_____

__Relationship breakup_____

__Difficulty making friends_____

__Am not assertive: business _____ personal_____

__OTHER CHALLENGES

_____

_____

_____