***Brittney Sounart***

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**INTAKE FORM:**  *This is a confidential record of your history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so. Please complete the questionnaire as thoroughly as possible. Feel free to skip any questions you feel uncomfortable answering. Thank you.*

*Directions:* ***Via computer****, put your cursor next to the "x" and begin typing. This allows you to use as much space as needed.*

Today's Date: x

Name: x

Phone #:

E-mail : x

Address : x

Birthday: x

Relationship Status: x

Emergency Contact Name & Relationship: x Phone number: x

Referred by *(or how did you hear about me):* x

***Goal-Related Questions:***

What is your main goal in working together? x

What is the main block/obstacle/issue that you hope to address? x

What triggers this issues most often, on an average day/week? *(ie. family event, criticism, social events, social media etc)*

Why are you reaching out now? x

Have you experienced any significant life events or traumas (even very young) that you feel have impacted you? If so, please list as few or as many as you wish to share.

Age/ Event description

What have you tried that has helped you this issue/goal? x

What have you tried that hasn’t helped? x

Have you seen other practitioners for this issue/goal? If yes, what was helpful vs. not helpful ?– x

***Daily Emotions and Stressors:***

***Next to each emotion/stressor, rate how strongly it affects you on an average day***

*(0 = does not affect me at all / 10 - extremely affects me)*

*EMOTIONS*

Stress, anxiety - x

Overwhelm- x

Insecurity, Jealousy - x

Guilt, shame - x

Uncertainty - x

Anger, resentment - x

Sadness, grief- x

Depression, loss of hope - x

Resistance, Procrastination - x

*STRESSORS*

Work stress - x

Financial stress- x

Career or School stress - x

Relationship stress - x

Health-related stress - x

Body Image- related - x

Fear or phobia related— *(describe)* - x

Painful memories or past trauma related *(describe)* - x

Major loss related *(list divorce, death, miscarriage, diagnoses, job relocation etc.)* - x

Other stressors *(describe)* - x

***Birth Story***

Are you adopted? **Yes No**

*(If YES, please share any relevant information)* – x

Were either of your parents or grandparents adopted? **Yes No**

*(If YES, please describe)* – x

Were there any birth complications? (premature/surgeries/ breach) **Yes No**

*(If YES, please describe)* – x

Were you separated from your mother (even for a few hours) immediately after you were born? **Yes No**

*(If YES, please share any relevant information)* – x

***Personal Medical History:***

Do you have any medical or mental health conditions(s)? **Yes No**

*(If YES, please describe)* – x

Did either of your paretns have any medical or mental health conditions(s)? **Yes No**

*(If YES, please describe)* – x

Have you ever been hospitalized for mental health issues? **Yes No**

*(If YES, please describe)* – x

Are you taking any prescriptions/ medications? -x

Have you ever thought of hurting yourself? **Yes No**

*(If YES, please describe)* – x

Are you now, or have you even been suicidal? **Yes No**

*(If YES, please describe)* – x

***Relevant Family History:***

Did you have a relationship with your parent(s) now/growing up? x - **Yes No**

*(If NO, please describe)* - x

Are your parents living? *(circle or underline Yes or No)* Mother - **Yes No |** Father - **Yes No**

Do you have siblings? - **Yes No**

*(If YES, briefly describe any applicable information)* - x

Did anyone other than immediate family live with you while growing up? **Yes No**

*(If YES, briefly describe any applicable information)* - x

Do you or anyone in your family have a history of substance abuse? Yes No

*(If YES, briefly describe any applicable information)* - x

***Relevant*** ***Spiritual Information* :**

Have you experienced anything in your religious/spiritual upbringing that you feel is related to your current issue? - **Yes No**

*(If YES, briefly describe any applicable information)* - x

If there is anything you would like me to know regarding your spiritual life, please share here - x

***Anything Else?***

Is there anything else you would like to share that I did not cover in my previous questions? x

**Prior to your 18th birthday**:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?  
   *(Underline one)* Yes No
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?  
   *(Underline one)* Yes No
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?  
   *(Underline one)* Yes No
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other?  
   *(Underline one)* Yes No
5. Did you often or very often feel that … You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
   *(Underline one)* Yes No
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason ?  
   *(Underline one)* Yes No
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?  
   *(Underline one)* Yes No
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?  
   *(Underline one)* Yes No
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?                        *(Underline one)* Yes No
10. Did a household member go to prison?  
    *(Underline one)* Yes No

**Rate Your Average Stress**

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Read each carefully, and pick the answer that indicates how much you have been bothered by that problem ***in the last month*.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No.** | **Response** | **Not at all**  **(1)** | **A little bit**  **(2)** | **Moderately**  **(3)** | **Quite a bit**  **(4)** | **Extremely**  **(5)** |
| **1.** | Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past? |  |  |  |  |  |
| **2.** | Repeated, disturbing *dreams* of a stressful experience from the past? |  |  |  |  |  |
| **3.** | Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)? |  |  |  |  |  |
| **4.** | Feeling *very upset* when *something reminded* you of  a stressful experience from the past? |  |  |  |  |  |
| **5.** | Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the  past? |  |  |  |  |  |
| **6.** | Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it? |  |  |  |  |  |
| **7.** | Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past? |  |  |  |  |  |
| **8.** | Trouble *remembering important parts* of a stressful experience from the past? |  |  |  |  |  |
| **9.** | Loss of *interest in things that you used to enjoy?* |  |  |  |  |  |
| **10.** | Feeling *distant* or *cut* off from other people? |  |  |  |  |  |
| **11.** | Feeling *emotionally numb* or being unable to have loving feelings for those close to you? |  |  |  |  |  |
| **12.** | Feeling as if your *future* will somehow be *cut short*? |  |  |  |  |  |
| **13.** | Trouble *falling* or *staying asleep*? |  |  |  |  |  |
| **14.** | Feeling *irritable* or having *angry outbursts*? |  |  |  |  |  |
| **15.** | Having *difficulty concentrating*? |  |  |  |  |  |
| **16.** | Being *“super alert”* or watchful on guard? |  |  |  |  |  |
| **17.** | Feeling *jumpy* or easily startled? |  |  |  |  |  |

**Thank you for your vulnerability in sharing! I greatly appreciate this.**