

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 lose 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
