Room to Breathe, Integrative Therapies

CLIENT INTAKE FORM

NAME _____ DATE_____

ADDRESS_____

E-MAIL_____

PHONE - Home:_____ Cell or Work:_____

OCCUPATION_____BIRTHDATE_____

EMERGENCY CONTACT PERSON (Name/relationship/number):
_____

How did you hear about this work/who referred you?_____

Where you are right NOW, on a scale of 1-10 in each of these areas:
(Remember: 5 is 'neutral', below 5 area = not working, above 5 area =working)

Spiritual Health/Practice:
Mental State:
Emotional Support:
Physical/Health:
Relationship/Family:
Home/House:
Purposeful Work:
Play/Spontaneity:
Creative Expression:
Friends:
Feelings of Abundance:
Other_____:

Why are you here? What is your intention for the session(s)?_____
_____

What physical, emotional and/or mental conditions are you experiencing that you would like to change?_____
_____

Are you under the supervision of any other therapist, counselor or psychiatrist?_____
If you want them contacted in the case of an emergency, please list their name and phone number_____

If appropriate, please list any medications that you are taking_____
_____

Do you remember or know about any details of your birth (Hospital or home birth, C-section, breech, cord around neck, anesthesia, etc.)? _____

What else would you like me to know?

Family Data – please list parents/step-parents/guardians, brothers/sisters, children:

NAME	RELATIONSHIP	AGE (or date deceased)

TELL US MORE ABOUT YOURSELF.

Name: _____ Sex____ Age ____ Email: _____ Tel: _____

Address:_____ City _____ State ___ Zip _____

Tell us about your breathing. Is breathing ever a challenge, or an issue, for you?

Medical conditions, e.g., cardiovascular, diabetes?

Respiratory disorders, e.g., asthma, COPD?

Injuries, past and present, e.g., chest, back, neck?

Physical complaints. e.g., headache, hypertension, stress symptoms?

Emotional challenges, e.g., panic, anxiety, anger?

Pregnancy experiences, current or previous?

Current prescriptions, e.g., depression, anxiety, hypertension?

Life traumas, e.g., emotional abuse, PTSD, chronic stress?

Pain issues, past or present, acute or chronic?

Physical limitations, e.g., fatigue, speech, movement?

Allergies and sensitivities, e.g., food, environment?

Deficiencies, e.g., electrolytes (kidney dysfunction)?

Relationship difficulties, or social challenges, e.g., significant other, “children,” employment?

Work related challenges, e.g., environment, unreasonable demands, co-workers, superiors?

Learning issues, e.g., attention deficit, memory, focus?

Performance issues, e.g., public speaking, testing, performing arts, operating technology?

Are you seeing a healthcare practitioner? If so, what kind of practitioner(s), e.g. physician?

Other Comments

INTERVIEW CHECKLIST

For learning about your breathing habits

This checklist has been designed to serve as a "guideline" for assisting you in exploring whether or not your breathing habits are consistent with optimal respiration, and if not, how they may be affecting you at specific times and places.

Name _____ **Date**_____ **Email** _____

Tel _____ **Sex** ____ **Age** ____ **Sig other?** ____ **Children?** ____ **Issue**_____

Do you think you might have a dysfunctional breathing habit? If so, what difficulties are you having that might be related to breathing?

_____

_____

Do you ever experience any of the 24 symptoms listed below? Check the **Y column** for "YES," **OR** the **N column** for "NO," after each symptom listed. If you checked YES, indicate *how frequently you experience the symptom* by checking a number 1 through 7, where 1 is rarely and 7 is daily. Then enter in the *situations in which you experience a symptom*, in the "situation column," by entering a number that corresponds to one of the 21 situations listed at the bottom of the page. For example, you might check column #6 for "dizziness" and then enter in situations #14 (expressing feelings) and #19 (learning new tasks). If the situation is not shown on the list, write it into the "comment" column. Focus on when, where, and with whom these symptoms may occur.

How often? 1 = rarely .....7 = every day

Do you experience the following? If so, how often?	*N*	*Y*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*Situations*	*Comment*
Chest tightness, pressure, or pain •		x				x					
Intentional breathing, purposeful regulation											
Blurred or hazy vision											
Dizziness, light-headedness, fainting •											
Disconnected, things seem distant											
Shortness of breath, difficulty breathing •											
Tingling or numbness, e.g., fingers, lips •											
Disoriented, confused											
Unable to breathe deeply •											
Muscle pain, stiffness, e.g., hands, jaw, back											
Not exhaling completely, aborting the exhale •											
Deep breathing, like during talking •											
Fast or irregular heartbeat											
Chest breathing, effortful breathing •											
Breath holding, irregular breathing											
Poor concentration, focus, memory											
Rapid breathing, panicky breathing •											
Fatigue easily											
Worried about my breathing •											
Mouth breathing •											
Hard to swallow, nauseous											
Can't seem to get enough oxygen •											
Hyper-aroused, can't calm down, anxious											
Unexpected mood changes (e.g., anger)											

***SITUATIONS: circumstances under which you experience the above symptoms**

(1) working (employment)
(2) resting (between tasks)
(3) performing (e.g., test taking)
(4) talking, eating, singing
(5) feeling anxious or worried
(6) feeling tired or stressed
(7) interacting in groups
(08) physical challenges, exercising
(09) being confronted by others
(10) traveling, unfamiliar places
(11) socializing, meeting people
(12) speaking in public, in groups
(13) feeling angry or upset
(14) intimacy, expressing feelings
(15) physical discomfort, pain
(16) meeting authority figures
(17) going to sleep, while asleep
(18) being accountable, in-charge
(19) learning new tasks, new info
(20) feeling unsure of self
(21) allergens, weather, foods

General comments:_____

_____

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