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Registration No. 93817
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Trauma Based Intake Form

Name:_____Date:_____

What brings you to therapy? What do you feel is the problem? (Be as specific as you can: when did it start, how does it affect you, symptoms and so on):

_____

_____

_____

Past history of counseling or emotional/health and/or difficulties/diagnoses:

_____

What would you like to get out of your sessions? What are your goals for coming into therapy? What would you like to see?

_____

_____

Please describe your immediate family &/or your support system?

_____

_____

Any current major medical problems or surgeries?

_____

Current Medication(s):_____

_____

Checklist of any past history of physical, emotional, relational, and psychological trauma, abuse or accidents. (Please explain the trauma on the line and age.)

Fetal Distress ❑ yes ❑no_____
Birth Trauma ❑ yes ❑no_____
Premature Birth ❑ yes ❑no_____
Verbal Abuse ❑ yes ❑no_____
Physical Abuse ❑ yes ❑no _____
Sexual Abuse (include rape) ❑ yes ❑no _____
In the presence of abuse or violence ❑ yes ❑no_____
Other inescapable attacks ❑ yes ❑no _____
Mugging or entry of home ❑ yes ❑no_____
Attempted assaults ❑ yes ❑no _____
Mental illness ❑ yes ❑no _____
Car accidents ❑ yes ❑no _____
Major injuries or burns ❑ yes ❑no _____
Hospitalizations ❑ yes ❑no _____
Major surgeries ❑ yes ❑no_____
Minor surgeries ❑ yes ❑no_____
Major sicknesses ❑ yes ❑no_____
Near drowning or suffocation (include choking) ❑ yes ❑no _____
Someone close to you dying ❑ yes ❑no _____
Natural or unnatural disaster ❑ yes ❑no _____
Relational and/or Emotional Trauma ❑ yes ❑no _____
Emotional Neglects or Abandonments ❑yes ❑no_____
Other traumas or overwhelming experiences ❑yes ❑no _____
_____

Check box next to what feelings apply: ❑ Moody ❑ Frozen and stuck ❑ anger ❑ Manic or elated ❑ Panic attacks ❑ Phobic ❑ Depressed ❑ Shortness of breath ❑ Obsessive ❑ Irritable ❑ Unexplained chest pain ❑ Compulsive ❑ Hopeless ❑ Heart palpations ❑ Impulsive ❑ Guilt and shame ❑ Dizzy ❑ Detached ❑ Anxious ❑ Nausea ❑ Do you have nightmares? ❑ Sad/tearful ❑ Often fearful ❑ Are you easily startled? ❑ Worthless ❑ Trembling

What do you do to relax? What brings you pleasure or joy?

_____
_____

Personal strengths & resources (within yourself and within your community):

_____
_____

Anything else you would like the therapist to know about you in order to better understand you:

_____
_____
_____

Client Signature: _____

Date of Signature: _____

PLEASE NOTE THAT THIS FORM WILL REMAIN IN A LOCKED AND SECURED LOCATION.