

Degriefing® Process Intake Form

(Please fill out as completely as possible.)

Name:		Today's date:		
Referred by		Nature of relationship?		
Contact Information:				
1	Mailing address:			
2	Telephone / Fax (home):			
3	Cell phone / (other):			
4	Work address:	Telephone / Fax (work):		
5	E-mail addresses: work:	Home:		
6	Emergency contact:	Telephone:		
Basic Personal Information:				
7	Place and date of birth:	Ethnic origin:		
8	Occupation:			
9	Employer:	Average commute time		
10	Hobbies or recreational activities:			
11	Are you right or left handed?	Repetitive motion activities?		
12	Favorite type of music?	Favorite book/movie?		
13	Do you have a pet?	If yes, please describe.		
14	What is your religious or spiritual affiliation?			
Family Profile:				
15	Are you single, partnered or married?	Sexual orientation? (optional)		
16	Are you a child of divorce?	Have you divorced?	Had traumatic separation?	
17	Who do you live with now?			
18	Do you have children?	How many?	Names/ages?	
19	Are your parents alive?	If deceased, when?		
20	Do you have siblings?	Where do they live/ages?		
21	Name/telephone of primary care physician:			
22	Date of last complete physical examination:	Prostate exam/Mammogram?		
23	Do you currently have medical/dental insurance?	What coverage?		
24	Do you wear eyeglasses or contacts?	Age first worn?		
25	Do you wear dentures/prosthesis?			
26	Do you regularly use substances?	alcohol?	tobacco? other?	
27	Surgical history?			
28	Last reported blood pressure:	Any medical restrictions/allergies?		
29	List all current medications:			
30	Please list any chronic conditions/illnesses in your family:			
31	Please indicate which of the following currently apply to you:			
	allergies	eating disorders	lower back pain	pregnancy
	arthritis	epilepsy	menopause	skin cancer
	asthma	headache	mid back pain	skin conditions
	athlete's foot	heart conditions	neck pain	tinnitus
	cancer	herpes	osteoporosis	upper back pain
	constipation / diarrhea	Hepatitis A, B or C	phlebitis	varicose veins
	diabetes	HIV	Plantar warts	vision problems
32	Do you currently have/or had, any contagious diseases or other conditions not listed?			
33	Have you suffered recent or old injury? If so, what/when?			
34	Any chronic or acute, physical or emotional pain?			

35	Please indicate which of the following currently apply:			
	depression	insomnia	irritability	confusion
	mood swings	anxiety	fear	paranoia
	apathy	compulsiveness	loss of appetite	exhaustion
	heartache	crying	overeating	panic attacks
	nervousness	anger	guilt	loss of memory
36	Other/please explain			
37	Preferred bed time?	Avg. amount of sleep	Do you remember your dreams?	
38	How would you assess your stress level?		On a scale of 1-10?	
Previous Therapeutic Experiences:				
39	Have you ever had a professional massage/bodywork before?			
40	Have you ever experienced any complementary / integrative (alternative) therapies?			
	acupuncture	dance therapy	meditation	storytelling
	Alexander Technique	Feldenkrais	Pilates	tai chi
	aromatherapy	flower essences	Reiki	vibrational
	breathwork	hydrotherapy	role playing	visualization
	chiropractic	hypnotherapy	Rolfing	yoga
41	Now engaged in other therapies?			
Current Activities:				
42	Do you exercise regularly?		Which form of exercise/how often?	
Loss related Questions:				
43	Have you suffered recent loss?	What loss/when?		
44	Why are you seeking treatment?			
45	What has prompted your visit?			

46. I have stated all my known medical, emotional and physical circumstances and will keep the Degriefing practitioner updated about changes in my condition.

47. I understand that Degriefing (i.e., a combination of verbal counseling and somatic treatments) is for the purpose of alleviating grief related ailments and promoting a sense of well-being. I understand that the Degriefing practitioner does not diagnosis illness, disease or any other physical or mental disorder; or prescribe medical treatments or remedies. The Degriefing process is not a substitute for licensed medical care, consultations or examinations.

48. My full payment is due at time at time of session/class/training unless prior arrangements are negotiated. I assume responsibility for full payment of any scheduled session that I cancel without at least 48 hours prior notice.

49. **I have read and agree to the above statements and conditions.**

Signature: _____ Date: _____

“Keeping bodies well ~ helping bodies heal”

Degriefing®
P.O. Box 1501, San Anselmo, CA 94979
415-457-2272
www.degriefing.com