Ultra Depth® International

Client Intake Form - Please Print

NAME: _____ **GENDER: F** ___ **M** ___

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **COUNTRY:** _____

HOME PHONE: _____ **E-MAIL:** _____

CELL PHONE: _____ **OCCUPATION:** _____

DATE OF BIRTH: _____/_____/_____
Month Day Year

HOW DID YOU HEAR ABOUT US: _____

REASON FOR REQUESTING OUR SERVICES: _____

_____

WHAT PREVIOUS EFFORTS HAVE YOU TAKEN TO RESOLVE YOUR SITUATION:

ARE YOU CURRENTLY UNDER CARE FOR ANY MEDICAL TREATMENT FOR THIS OR ANY OTHER SITUATION: YES ( ) NO ( )

BRIEF DESCRIPTION OF YOUR SITUATION: _____

_____

_____

HAVE YOU EVER HAVE ANY PROLONGED ILLNESS: YES ( ) NO ( )

HAVE YOU EVER BEEN OR ARE YOU CURRENTLY BEING TREATED FOR THE FOLLOWING:

DIABETES ___ **EPILEPSY** ___ **HEART CONDITION** ___ **HIGH BLOOD PRESSURE** ___ **ULCERS** ___

ASTHMA ___ **NERVOUS BREAKDOWN** ___ **ARTHRITIS** ___ **MIGRAINES** ___ **STRESS** ___

ALLERGIES ___ **CANCER** ___ **DEPRESSION** ___ **OVERWEIGHT** ___ **UNDERWEIGHT** ___

SMOKING ___ **DRUG ADDICTION** ___ **PHOBIAS** ___ **OTHER** _____

ARE YOU PREGNANT: YES ( ) NO ( ) IF SO, ENTER DUE DATE: _____

ARE YOU CURRENTLY OR HAVE BEEN TAKING ANY MEDICATIONS: YES ( ) NO ( )

If you marked "YES", please list what medications and for what purpose: _____

_____

_____

DO YOU SMOKE TOBACCO: YES ( ) NO ( ) How much per day: _____

How long have you been using tobacco: _____ **What brand:** _____

IF YOU DRINK ALCOHOL, HOW MUCH AND HOW OFTEN: _____

DO YOU HAVE ANY PROBLEMS EATING OR DIGESTIVE DISORDERS: YES ( ) NO ( )

If you marked "YES", Explain: _____

_____

DO YOU EAT WHITE FLOUR PRODUCTS
(i.e., bread, crackers, pretzels, pasta, pizza, etc): YES ( ) NO ( )

DO YOU DRINK SOFT DRINKS
(Pepsi, Coke, Root Beer, etc.): YES ( ) NO ( )

DO YOU EAT FAST FOODS (McDonald's, Burger King, Wendy's, etc.): YES ( ) NO ( )

DO YOU EAT DAIRY PRODUCTS: YES ( ) NO ( )

WHAT TYPE OF WATER DO YOU DRINK:
TAP ( ) FILTERED ( ) BOTTLED SPRING ( ) BOTTLED DISTILLED ( )

HOW MUCH WATER DO YOU DRINK DAILY: _____

IN YOUR KNOWLEDGE, WERE YOU EVER HYPNOTIZED BEFORE: YES ( ) NO ( )

If you marked "YES", by whom, why and what were the results: _____

_____

_____

DO YOU PRACTICE ANY FORM OF RELAXATION or MEDITATIVE TECHNIQUES: YES ( ) NO ( )

If you marked "YES", please explain what and how long: _____

_____

DO YOU SLEEP SOUNDLY: YES ( ) NO ( )
ON THE AVERAGE HOW MANY HOURS DO YOU SLEEP EACH NIGHT:
Less than 6 hours ( ) 6 - 8 hours ( ) More than 8 hours ( )

UPON AWAKENING, HOW LONG DOES IT TAKE BEFORE YOU FEEL FULLY ALERT:
Less than 5 minutes ( ) Up to 15 minutes ( ) Up to 30 minutes ( )
More than 30 minutes ( ) Over an hour ( )

DO YOU TAKE TIME FOR SELF IMPROVEMENT: YES ( ) NO ( )

If you marked "YES" please list examples: _____

_____

DO YOU HAVE ANY FEARS OR PHOBIAS: YES ( ) NO ( )

If you marked "YES", please explain: _____

_____

_____

FOR THE FOLLOWING ITEMS, PLEASE FILL IN THE NUMBER OF HOW YOU WOULD RATE IT:
0=NONE 1=MILD 2=MODERATE 3=SEVERE

MARRIAGE ___ DIVORCE/SEPARATION ___ ALCOHOL/DRUGS ___ PRE-MARTIAL ___
CHILD CUSTODY ___ ANGER CONTROL ___ SINGLENESS ___ DISABLED ___ GRIEF/LOSS ___
SEXUAL ISSUES ___ WORK/CAREER ___ DEPRESSION ___ FAMILY ___ SCHOOL/LEARNING ___
FEAR/ANXIETY ___ CHILDREN ___ MONEY/BUDGETING ___ COMMUNICATION ___
PARENTS ___ AGING/DEPENDENCY ___ LONELINESS ___ IN-LAWS ___ WEIGHT CONTROL ___
MOOD SWINGS ___ GOD/FAITH ___ PAST HURTS ___ INTIMACY ___ CHURCH/MINISTRY ___
CO-DEPENDENCY ___ OTHER ADDICTIONS ___ SELF-ESTEEM ___ STRESS MANAGEMENT ___

OTHER (Specify): _____

DO YOU HAVE ANY BEHAVIOR PATTERNS THAT YOU WISH TO CHANGE: YES ( ) NO ( )

If you marked "YES", please describe: _____

_____

WHAT DO YOU EXPECT FROM THESE SESSIONS: _____

_____

_____

DO YOU HAVE ANY QUESTIONS ABOUT THIS TYPE OF CONSULTING SERVICE: YES ( ) NO ( )

_____

_____

I ACKNOWLEDGE UNDERSTANDING ALL QUESTIONS AND THE INFORMATION THAT I HAVE GIVEN, IS COMPLETE ANDACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS FORM OF CONSULTING IS NOT A SUBSTITUTE FOR MEDICAL TREATMENT. THIS IS TO BE USED AS INFORMATION FOR BALANCE AND ENVIRONMENT. I AM AWARE THAT THIS IS NOT A PRESCRIPTION NOR DIAGNOSIS. I AM FULLY AWARE THAT MY SUCCESS DEPENDS ON ME DOING THE EXERCISES AS INSTRUCTED.

CLIENT'S OR GUARDIAN"S SIGNATURE: _____

DATE: _____/_____/_____
Month Day Year

ALL INFORMATION ABOVE IS STRICTLY CONFIDENTIAL AND CANNOT BE RELEASED TO ANYONE WITHOUT YOUR WRITTEN CONSENT