

Ultra Depth® International

Client Intake Form - Please Print

NAME: _____ GENDER: F ___ M ___

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ COUNTRY: _____

HOME PHONE: _____ E-MAIL: _____

WORK PHONE: _____ EXT: _____ 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 ___ SINGLENES ___ 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 COUNSELING SERVICE: YES () NO ()

I ACKNOWLEDGE UNDERSTANDING ALL QUESTIONS AND THE INFORMATION THAT I HAVE GIVEN, IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS FORM OF COUNSELING 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