

EFT Coaching Intake Form

Date:

Name:	Referred by:	
Address:	City, State, Zip:	
Home Phone:	Cell Phone:	Skype:
Email:	Date of Birth:	
Occupation:	Hobbies:	
Emergency Contact:	Phone:	
Relationship Status:	Children:	
Other Members of the Household:		

Mark all the issues you would like to work on:

<input type="checkbox"/> Stress or Overwhelm <input type="checkbox"/> Anxiety <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Fears or Phobias <input type="checkbox"/> Depression <input type="checkbox"/> Traumatic Memories <input type="checkbox"/> Lack of Joy <input type="checkbox"/> Lack of Purpose <input type="checkbox"/> Anger, Resentment, Frustration <input type="checkbox"/> Grief-Loss <input type="checkbox"/> Other Issues:	<input type="checkbox"/> Divorce or Breaking up <input type="checkbox"/> Sexual Difficulty <input type="checkbox"/> Weight Issue <input type="checkbox"/> Relationship/Interpersonal Problems <input type="checkbox"/> Financial Difficulties <input type="checkbox"/> Procrastination <input type="checkbox"/> Workaholic <input type="checkbox"/> Self-esteem <input type="checkbox"/> Business Performance <input type="checkbox"/> Smoking
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Have you done EFT before?	With a practitioner?				
Do you have a history of:					
Chronic Pain	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Epilepsy or Seizures</td> <td style="width: 50%;">Panic Attacks</td> </tr> <tr> <td>Asthma</td> <td>Anaphylaxis</td> </tr> </table>	Epilepsy or Seizures	Panic Attacks	Asthma	Anaphylaxis
Epilepsy or Seizures	Panic Attacks				
Asthma	Anaphylaxis				

Are you feeling suicidal? Or have you been in the past? If so, when? And why?

Do you or anyone in your family have a history of substance abuse?

Please list your past health concerns – since childhood (including illness, accidents, surgery):

Are you taking any medications that may effect you mentally or emotionally?

Do you have a medical or psychiatric condition I should know about?

Did you grow up with siblings? What was the birth order?

Did you have a strong religious upbringing?

List any foods foods or substances to which you know or suspect you may be allergic or sensitive:

If possible, please avoid these foods/substances for at least 24 hours before your scheduled appointment.

What issue or issues would you like to start with? What is the most upsetting aspect at this time?

If possible, please include any memories that you think are involved. How do you feel about the issue? When did it start and what was going on at the time?

How would you like to feel after our session? What would success look like?

What are three positive goals you would like to achieve?

How would your life be different if and when all of your issues are resolved?

Is there anything else you would like for me to know?
