



Registered Clinical Counsellor

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Intake Form

Name

Birth-date

Address

City

Postal Code

Phone

Messages ok? Yes No

Email

Do you want to be added to my email list for upcoming workshops/ classes?

Yes/No

Emergency contact

Relation?

Phone

Family Doctor

Naturopathic Physician

Your other health professionals

Medications

Herbal supplements/vitamins

Previous surgeries and hospitalizations (include dates)

Do you have any health concerns?

Do you Experience: please check any that apply and put a p for one's you've experienced in the past

- depression
- anxiety
- panic attacks
- post traumatic stress disorder
- difficulties sleeping (too much; too little; falling asleep; frequent waking)
- lethargy, exhaustion
- outbursts of anger/rage
- difficulties relaxing
- overwhelm
- feelings of helplessness or being powerless
- self-harming behaviours – cutting/scratching/burning/other
- thoughts of death or dying
- disordered eating
- reoccurring dreams or nightmares
- feeling out of control
- high startle response
- irregular or painful menstruation
- constipation/diarrhea
- ulcers
- chronic pain
- migraines
- chronic fatigue syndrome
- fibromyalgia
- autoimmune illnesses
- heart disease
- hypothyroidism/hyperthyroidism
- other_____

Do you currently use any of the following (indicate how often, how much and for how long):

Alcohol

Tobacco

Coffee

Soft drinks

Black tea

Marijuana

Other substances

Describe your current living arrangements

Are you in a significant or intimate relationship yes/no? If yes, for how long?

Are you currently: working/student/ looking for work/retired/other

How would you describe your stress level?

Do you have a relaxation practice?

What kind of exercise schedule do you keep?

How did you hear about me?

Can I send a thank you card to this person?