Somatic Experiencing Intake Form

Welcome! Please fill in the following information so that I can better support you in your Goals for Care.

Name________________________ **Pronouns**________________________

Address____

Street City State Zip Code

Best Phone # for you: ____________________ **Email** ____________________

Date of Birth: ________________ **Relationship status**____________________

Children, Name(s) & Age(s): ____

Emergency Contact: ____________________**Relationship to you:** ____________

Occupation:____

Why are you interested in having a Somatic Experiencing Session? ____________

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Are you currently taking any medications? ________________________________

What are they for?____

Have you had any surgeries, motor vehicle accidents, hospitalizations or Injuries?

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Are you currently working with another healing professional? ______________

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What makes you come alive?____

What brings you joy, comfort, peace?____________________________________

Anything else you'd like to share that would better help me to understand you?______

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Thank you !

Dr. Catherine Hondorp, M.F.A., D.C., S.E.P