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Trauma Education
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Date: _____
Name: _____

Address: _____

_____

Phone: _____

Resources: things, places, relationships, or activities that:

1). calm you down, _____
2). engage you, _____
3). bring you pleasure_____
4). help you sleep _____

Reason for coming for trauma education:_____

_____

Limitations: (from injury or P.T.S.D.): *circle and/or describe relevant issues:*

Physical pain, limited strength, movement, stamina. _____

Social - communication issues, easily overwhelmed, angry, hypervigilant, overly reactive to touch.

_____

Environmental, - allergies, sensitivity to noise, light, distractions, _____

Cognitive -challenges with decision making, concentration, following directions, taking in or re-membering information _____

Stress sensitivity - inappropriate reactions, emotionally fragile, reactive to competition, deadlines,

_____

Weekly activity level - (sports, home life, job requirements,):_____

_____

When you have a good day, what makes it better than other days?_____

_____

_____

Fears or concerns I should know about?

Learning choice?

In case you want bodywork:
Relevant injuries and operations (Anything that causes you pain, or that I should know about before working with you):_____

_____

Experience with bodywork? _____
What reaction? _____

_____

Regarding Confidentiality:
Your verbal communications and client file are kept confidential except as required by law.

Medical History

Name_____

Indicate below any significant medical conditions as they can influence the type or depth of work appropriate in a given area.

__Skin condition - acne, rash, allergies, skin cancer, other:_____

__Lymphatic condition - swollen glands, lymphoma, lymphedema, other:_____

__Recent injury - whiplash, sprain, deep bruise, other:_____

__Circulatory condition - heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, other:_____

__Neurological condition - sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other:_____

__Joint problems, pain or stiffness - osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other:_____

__Bone conditions - osteoporosis, previous fracture, cancer, other:_____

__Headaches - migraines, PMS, tension, cluster, other:_____

__Emotional difficulties -depression, anxiety, psychotic episodes, other:_____

__Stress - from_____

__Previous surgery - type and date_____

__**List any medications you are currently taking:**_____

Habits:

Posture assumed most of the day_____

Time and type per week Exercise_____

Tobacco_____ Alcohol_____ Sleep issues_____

Caffeine_____ Drugs (non med)_____

Name of health care provider_____Phone_____

Do I have your permission to contact him/her should the need arise?_____

Your signature: _____

Body/Mind/Spirit Name_____

(This page is optional, but can be helpful)

What is your spiritual perspective or discipline, if any ?
(Please briefly outline your beliefs and practices, if any.)

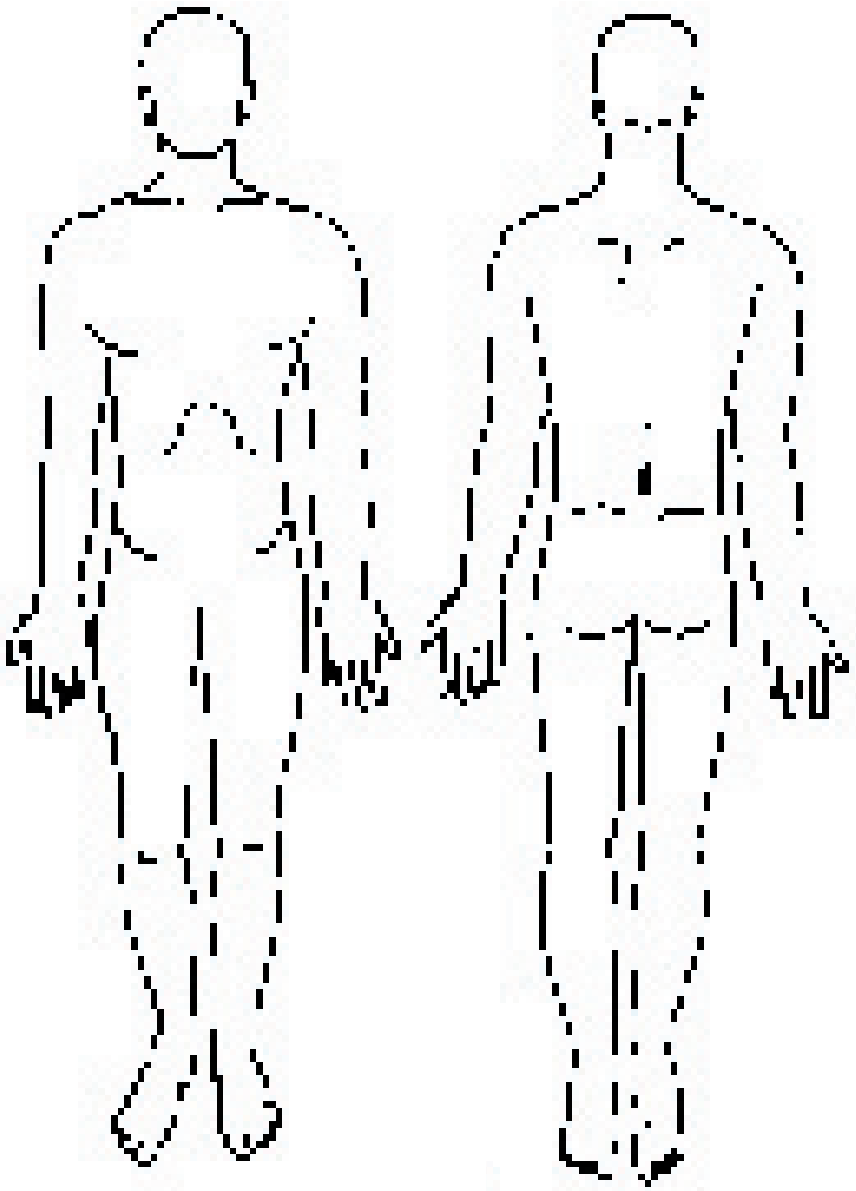
Do you have any experience with psychotherapy or personal growth work?
What kind? How much? When? With what reaction?

How is your capacity to allow/ feel /express the following emotions?
GRIEF
ANGER
FEAR
JOY
LOVE

Do you have experience with energy work, oriental medicine, other mind/body approaches?
Which? When? What response?

Body/Mind/Spirit

Especially if you have pain or persistant symptoms,
mark areas of pain or other sensation and rate:
1- mild, 2- moderate, 3- severe



Front Back

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