Peaceful Healing Solutions, LLC

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New Client Form (Adult) Date ___________

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name: ____________________________________ Gender: ________ Age: ______ DOB: _____________

Address: ____________________________________ City: ________________ State: ____ ZIP: ________

Home Phone: ______________________ Work Phone: ___________________ Cell Phone: ______________

Email Address: _________________________________ Soc. Security # ____________________________

Emergency Contact: _______________________ Relationship: ______________ Phone: ______________

Place of Birth: _________________ Ethnic/Cultural Background: _________________ Religion: ____________

Native Language: ________________ Marital Status: _______________ Education: ____________________

Occupation: _______________________ ______ Employer: _____________________________________

How did you hear about EFT? ____

Current Issues

Please provide a brief description of what you would like to change:____________________________________
____
____
____

Has anything happened that may have brought on/intensified the problems you are experiencing? ☐ Yes ☐ No
If yes, please explain: ____

When (month/year) did you first begin to experience these problems? _________________________________

How many days, weeks, months, or years have you been experiencing these problems? __________________

How much is/are the problem(s) affecting you? ☐ Mildly ☐ Moderately ☐ Severely

In what areas do your problems impact your life? (Check all that apply)

☐ Lifestyle (the way you live your life)

☐ Activities (things you normally do or would like to do)

☐ Relationships (your ability to form or maintain relationships with others)

☐ Eating

☐ Sleeping

☐ Mood

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when? ______________)
Have you been thinking about suicide? ☐ Yes ☐ No

Have you ever experienced or witnessed a traumatic event? ☐ Yes ☐ No
If yes, please explain ____
____

Have you had a significant loss or had someone close to you die? ☐ Yes ☐ No

Life Questions

Pease list the current prescription and over-the-counter medications you are currently taking:

Please list any medical issues you are experiencing:

Problems or changes in my family or other important interpersonal relationships (include name of person and relationship):

If you were to live life over, what person or event would you prefer to skip?

What makes you angry and why?

What was the last time you cried and why?

What is your biggest regret or sadness?

What is missing in your life to make it ideal?

Who would be upset if you were completely "healed"?

What do you wish you had never done?

What is one positive goal you would like to achieve?

How would your life be different if/when we handle all of your issues?

What would you like to change in your life?

What else do you want me to know:

Symptom Checklist

Directions: Place a check next to any problems that are impacting your life. Next to the checkbox, rate how much it is affecting you on a scale of 1 – 10 with 1 meaning its impact on your life is very little, and 10 meaning its impact is tremendous.

€	Depression	€	Performing unusual rituals or habits
€	Low energy	€	Impulsiveness
€	Low self-esteem	€	Excessive behaviors (Examples: spending, gambling)
€	Poor concentration	€	Delusions / hallucinations (Thinking / believing / seeing / hearing unusual things
€	Lack of interest/enjoyment in life	€	Sexual problems
€	Feeling hopeless	€	Self injurious behaviors
€	Feeling worthless	€	Shyness
€	Feeling guilty or shameful	€	Social skills
€	Sleep changes (more/less)	€	Social support (family/friends)
€	Loneliness	€	Stealing
€	Bad dreams/nightmares	€	Strange, weird, or peculiar behavior
€	Feeling Ignored or Abandoned	€	Confusion/can't think clearly
€	Appetite changes (more/less)	€	Feeling "not real"
€	Mood swings	€	Feeling detached from yourself
€	Thoughts of hurting self	€	Feeling "hyper"
€	Thoughts of hurting others	€	Financial problems
€	Isolating from others/social withdrawal	€	Grief/bereavement
€	Feelings of sadness/loss	€	Health problems
€	Weight problems	€	Impact of your problems on others
€	Stress	€	Losing track of time
€	Anxiety/tension/worry	€	Problems with memory
€	Panic attacks	€	Can't hold onto an idea
€	Heart racing	€	Anger/frustration
€	Chest pain or heaviness	€	Suspiciousness or mistrustfulness
€	Chills / hot flashes	€	Problems trusting others
€	Tingling/numbness	€	Easily irritated/annoyed
€	Pain	€	Aggressiveness
€	Fear of dying	€	Unpleasant thoughts that won't go away
€	Fear of going "crazy"	€	Bothered by recurring thoughts
€	Nausea	€	Job/career problems or indecision
€	Fears or phobias	€	Destruction of property
€	Obsessions/compulsions	€	Self-criticism
€	Perfectionist behavior	€	Use of alcohol
€	Lying	€	Use of drugs
€	Making/keeping friends	€	Blackouts
€	Arguing with others	€	Physical abuse
€	Trouble with the law	€	Sexual abuse
€	Family problems	€	Partner abuse
€	Marital/relationship problems	€	Thoughts racing
€	Parent/child problems	€	Disorganization