

# Trauma Touch Therapy™

## Client Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ (day) \_\_\_\_\_ (evening)

Occupation: \_\_\_\_\_

Birthdate: \_\_\_\_\_ -Age \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone \_\_\_\_\_

Counselor Name: \_\_\_\_\_ Phone \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Why are you seeking Trauma Touch Therapy at this time?

How have you worked with your concerns prior to seeking Trauma Touch Therapy?

Have you ever had any experience with bodywork?

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If so, how do you feel about your session(s)?

Have you had any experience with psychotherapy or counseling?

For your information:

As a Trauma Touch Therapist, I am not qualified to make any diagnosis or prescribe any treatments. All recommendations are to be viewed as suggestions. All sessions are confidential. All sessions are strictly non-sexual in nature.

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### - Client Responsibility Agreement

I agree that I am responsible for my well being while participating as a TTT client.

I agree to be responsible for my participation in, and creation of, this therapy.

I agree to take responsibility for my truth, my feelings and needs, and whatever issues arise for me and ask for support when necessary.

I am willing to have learning and transformation happen in ways that are totally loving and kind to me and everyone else.

Signature \_\_\_\_\_ Date: \_\_\_\_\_