

Participant Intake Form

Use this form at your first session with your participant to learn about their overall situation and needs.

(Provider, please go through this quickly. No need for detail, just high-level overview.)

Provider Name _____ **Participant initials** _____ **Date** _____

___ You have told them that “Everything in this session is confidential unless you tell me that you are going to harm yourself or someone else.”

Other information

Pronouns (optional) _____

Medical Diagnosis

Medical Treatments/Surgeries

Medications

Are you employed? Full time or part-time?

Living Situation/Support system

Relaxation/self care

Rating Scale of 1-5 (1 = lowest, 5 = highest)

CHALLENGES

POSITIVES

Pain level _____	Optimism _____
Depression _____	Comfort Level _____
Stress/Anxiety _____	Mental Clarity _____
Fatigue _____	Sleep _____
Other _____	Energy level _____
_____	Spiritual Connection _____
	Other _____

What do you hope to gain from this program? (What should we focus on?)

Do you have a religious or spiritual practice?