Confidential Client Application/Intake Form

1st Appointment Date: ________ / Time:_________ TYPE OF SESSION: Phone___ or Office____

NAME: ________________________ HOME #:___________________WORK/CELL#:___________________

ADDRESS: ______________________________CITY:________________ ST:_____ZIP:_______________

D.O.B.___/___/___ SEX:___ MARITAL STATUS:_____ SPOUSE or SIG.OTHER:________________________

E-MAIL:__________________________________HOW DID YOU HEAR ABOUT US: ____________________

OCCUPATION: ____________________________COMPANY:______________________________________

OTHER MEMBERS OF HOUSEHOLD AND AGE____

____

To prepare for sessions, please watch the intro video on the home page of www.MTTassoc.com and practice the Tapping Points with the video on the "Basics" page.

Below, check *all issues* you would like to work on. – **Put an X by the most urgent issues**:

__Depression or grief
__Weight Issues or Self Esteem
__Chronic or Current Pain
__Stress/Anxiety
__Relationship Challenge(s)
__Fears or Phobias
__Being More Effective at Work (or home)
__Balancing Work and Personal Life
__Sports Performance (Golf, Tennis, Skiing, etc)
__Anger, Frustration, or Resentment
__Past Trauma or Painful Memory
__Experiencing more joy and/or peace of mind

Issues not mentioned above:
____

The following answers will help us in our sessions:

Have you seen a therapist for these or any other issues, and if so, when? (Please indicate what kind of therapist)
____

What, if any, medications are you taking?
____

Are you now, or have you ever been suicidal? ____ If so, when? _______and why?
____

Do you or anyone in your family have a history of substance abuse? If yes, please specify:
____

Do you have any medical condition(s) of which I need to be aware?
____

____

Please answer the following questions: (Feel free to use additional page(s) for more detail.)

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

2. What makes you angry and why?

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3. What was the last time you cried and why?

4. What is your biggest regret or sadness?

5. What is missing in your life to make it ideal?

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

7. What do you wish you had never done?

8. What is one positive goal you would like to achieve?

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

10. What would you like to change in your life?

You must read and agree to the following waiver before your session:

The information Karin Davidson is providing to me is only as general information. As part of the information presented and work we are doing together, I understand that I will be introduced to modalities called Emotional Freedom Technique ("EFT"), Meridian Tapping Techniques ("MTT") and other energy practices which are techniques referred to as a type of energy therapy. Due to the experimental nature of EFT and MTT, I agree to assume and accept full responsibility for any and all risks associated with utilizing EFT, MTT and other energy practices; and using EFT and MTT as part of my participation in single or group sessions. The information presented including introducing EFT or any other technique, is not intended to represent that EFT and MTT or any other technique, is used to diagnose, treat, cure, or prevent any disease or psychological disorder. EFT and MTT or any other technique is not a substitute for medical or psychological treatment. Any stories or testimonials presented do not constitute a warranty, guarantee, or prediction regarding the outcome of an individual using EFT and MTT or any other technique demonstrated for any particular issue. I understand that Karin Davidson accepts no responsibility or liability whatsoever for the use or misuse of the information or techniques presented, including, but not limited to, EFT and MTT demonstrations, training, suggestions, sessions, and related activities. I understand Karin Davidson strongly advises that I seek professional advice as appropriate before making any health decision(s). If I am on any medications, I understand I am NOT to change any dosages and should consult my physician or the professional who prescribed my medications.

Signature Date

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