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Transforming Touch® Somatic Therapy Intake Form

Today's Date: _____ Name: _____

Mental Health History

Please fill out the following health history questions.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication, including psychiatric? □ Yes □ No
If yes, please list: _____

How would you rate your current mental/emotional health? (Please circle or highlight one):
Poor / Unsatisfactory / Satisfactory / Good / Very good

Please list any specific health problems you are currently experiencing: _____
_____

Have you ever been diagnosed with a personality disorder or any other mental health disorder? If so, please describe: _____
_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

Retained Primitive Reflexes/Primary Movement Patterns

Please check any of the following signs indicating overactive reflexes:

Group 1:			
Shallow Breathing	Constantly Feeling Overwhelmed	Extreme Shyness	Disordered Eating
Feeling Stuck	Greater Than Normal Fear of Embarrassment	Depression, Isolation, Withdrawn	Sleep Disorders
Perfectionism			

Group 2:			
Difficulty with Transitions	Cycles of Hyperactivity and Fatigue	Difficulty with Vision and/or Reading	Very Sensitive to Light, Movement, Sound, Touch, or Smell
Easily Angered	Difficulty Settling	Dislike Change or Surprise	Motion Sickness

Group 3:			
Balance and Coordination Struggles	Motion Sickness	Toe Walking	Never Crawled
Fear of Heights	Poor Organization	Poor Sense of Time	

Group 4:			
Tension Headaches	Fidgety	“W” Sitting	Difficulty Reading and Writing
“Bear” Crawl Instead of Knees on the Floor	Messy Eating		

Determining Your Attachment Style

Please check any of the following statements regarding how you relate to and connect to others. The term "relationship" applies to all relationships, not just romantic.

Group 1:
Satisfied in Relationships
See Parent(s) as a Secure Base
Feel Safe and Connected with Friends/Family
Feel Safe and Comfortable Relying on Others or Having Others Rely on You
Trust, Harmony, Ability to Work Through Conflict in a Constructive Manner, Overall

Group 2:
Constant Desire for More & More Connection
Willing to Self-Abandon in Order to Connect with Others
Cling to Partner as Attempt to Derive Safety
Deeply Fear Abandonment or Time Alone
People Pleasing
Out of Touch with Own Feelings and Needs

Group 3:
Desire to Maintain Distance from Others/Avoid Vulnerability
Self-oriented Perspective, Believe Everyone is Responsible for Self and Should not Rely on Others (ie, Independence > Interdependence)
Meets Needs by Relying on Creature Comforts
Out of Touch with Own Emotions

Group 4:
Afraid of Abandonment While Also Fearing too Much Closeness
Swing Between Fear of Abandonment and Fear of Relying on Others
Can Be Overwhelmed by Own Emotions and Express Volatility in Relationships
Often Feel Confused and Exhausted by Relationships, as Relationships Bring Many of Your Triggers and Fears to Light
Crave Depth of Connection and Fear/Distrust it Simultaneously
Many Highs and Lows in Relationships