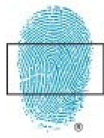


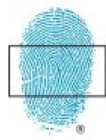
Client Information Form - Somatic Experiencing

Name: ____ Birth Date: _____________
Address: _____________________________ City _____________ State ____ Zip _________
Preferred Contact Method: **o** (Cell) ______________ **o** (E-mail) ____________________
Occupation: ____
Referred by: ____
Emergency contact person: ____________________________ Phone: __________________

oYes o No Have you previously experienced bodywork? What kind?________________
oYes o No Are you currently under a physician's care for any condition? Please describe: ________
____
Physician's name: _______________________ Phone: _____________ Fax:_____________
Primary reason for today's visit, (please explain):________________________________
____
Areas of complaint, pain, tension, (please explain): ______________________________
____

Please answer the following questions:

o Yes o No Do you wear contact lenses?
o Yes o No Do you wear dentures?
o Yes o No Do you have arthritis? What type and where? Please describe: ______________
____
o Yes o No Do you have any heart problems? Please describe: _______________________
____
o Yes o No Do you have any spinal problems? Please describe: ______________________
____
o Yes o No Are you presently pregnant? How far along? Complications? _______________
____
o Yes o No Do you have varicose veins or blood clots? Please indicate where:___________
____
o Yes o No Do you have any skin problems, diseases, or open sores? Where?____________
____
o Yes o No Have you had surgery? How recently? Complications? ____________________
____
o Yes o No Do you take any prescribed medications? Please list: ____________________
____
o Yes o No Do you take supplements, herbs, and/or vitamins? What kind? _____________
____
o Yes o No Do you exercise or play sports on a regular basis? Please describe: ___________
____



mti physical therapy
PROVIDING ONE-TO-ONE CARE

Client Information Form - Somatic Experiencing

o Yes o No Are you receiving any other complementary care currently, (chiropractor, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy)? If so, please describe:____________________

____

o Yes o No Do you have any other physical or mental condition of which I should be aware before giving you a massage therapy treatment? If yes, please describe:____

____

Session Description
Sessions are 60 minutes in length. As we work together, we will both be assessing the process. While some clients may need only a few sessions, others may benefit from more sessions over a longer period of time. You are in complete control and may end the sessions at any point.

Consent to Participate in Sessions
Please read the following statements and sign below so that we are clear about the parameters of our sessions. If you have any questions, please feel free to discuss them with me.

- I understand that David Benoff is a certified Somatic Experiencing® Practitioner
- I give David Benoff permission to facilitate my inner exploration using the modalities of Somatic Experiencing® and meditation
- I understand that I may terminate my sessions at any time and that, at termination, a closure session is generally recommended
- I understand any information I provide during SE sessions with David Benoff is confidential. David will not disclose information without my consent except as indicated below:
    - If I demonstrate credible threat to harm others or myself
    - Any information that indicates neglect or abuse of a minor child or dependent adult or elder abuse
- I give David permission to use touch if he and I consider it appropriate for facilitating my exploration. I understand that this touch is not intended to manipulate tissue, is non-sexual, and is only used when necessary for the support of awareness. I also understand that it is my responsibility to inform David if I am at any time uncomfortable with touch

If you do not want to incorporate the support of touch in your sessions, please sign here:

____

Client Printed Name:____

Client Signature: ____

Practitioner Signature:____ Date: ______________