KATSCRATCH.ONLINE

INNER EDGE | Vital Insights | PSYCH-ish

INTEGRATIVE DEVELOPMENT + NERVOUS-SYSTEM SUPPORT

Intake Form | 2026

SECTION 1 — WELCOME + CLIENT CHOICE

Thank you for taking the time to complete this form.

You may skip any question or pause at any time.

If anything feels activating, you may return later or bring it into our work together.

How would you like to complete this intake?

☐ Digital form ☐ Paper version ☐ I hate forms

SECTION 2 — IMMEDIATE SAFETY CHECK-IN

In the past two weeks, have you had thoughts of harming yourself?

☐ Yes ☐ No

Are you currently having thoughts of harming someone else?

☐ Yes ☐ No

Have you used alcohol or substances in the past 24 hours in a way that concerns you?

☐ Yes ☐ No

Are you experiencing a medical emergency or severe withdrawal symptoms?

☐ Yes ☐ No

INITIAL HERE _____

SECTION 3 — BASIC INFORMATION

Name	
Sex/Gender	
Date of Birth	
Address	
Phone(s)	
Email	

Emergency Contact Information

Name	
Relationship	
Phone(s)	

SECTION 4 — BACKGROUND + HEALTH HISTORY

Household + Social Context

This helps me understand the context you're living in and the supports around you. You may share as much or as little as feels comfortable.

Marital status: _____

Children (ages/sex): _____

_____

Occupation: _____

INITIAL HERE _____

Personal Health History

These questions help identify any physical factors that may influence your well-being.

Past surgeries:	
Significant illnesses:	
Hospitalizations:	_____ _____ _____
Allergies:	

Family Health History

This section helps identify patterns that may be relevant to your experience.

Significant family illnesses and/or hereditary conditions: _____

_____

SECTION 5 — PRESENT EXPERIENCE

This information helps me understand what feels most important to you right now. You may share whatever feels safe and relevant. If helpful, you may mark any areas of tension, pain, or concern on the body outline and on the pain scale.

Pain Scale

What brings you here *at this time*? _____

_____

_____

What would you like to *feel or experience* differently?

_____

_____

INITIAL HERE _____

_____

SECTION 6 — CURRENT FUNCTIONING

These questions help identify patterns in your daily functioning that may affect your overall well-being.

Sleep

☐ Restful ☐ Difficulty falling asleep ☐ Waking during night ☐ Nightmares ☐ Other

Appetite

☐ Typical ☐ Increased ☐ Decreased ☐ Stress-related changes

Concentration

☐ Steady ☐ Sometimes difficult ☐ Often difficult

Daily Responsibilities

☐ Going well ☐ Manageable ☐ Stressful ☐ Affecting performance

Relationship

☐ Supportive ☐ Mixed ☐ Strained ☐ Isolating

SECTION 7 — BODY CUES + REGULATION

This section explores how your body responds to stress and safety in daily life (for example: tension, breathing changes, restlessness, calm).

What cues or sensations do you notice when stressed or overwhelmed? What do you do to calm down?

_____

_____

SECTION 8 — SUBSTANCE USE (Optional)

This information helps me understand any factors that may influence your nervous system or daily life. You may skip this section if you prefer.

Has substance use created challenges? ☐ yes ☐ no

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Not at this time ☐ Prefer not to say

Share whatever is comfortable in your own words: _____

_____

INITIAL HERE _____

SECTION 9 — TRAUMA EXPOSURE (Optional)

This section is optional and meant to give you choice in how, when, or whether you share past experiences that may still affect you.

Have you experienced events that continue to affect you?	☐ Yes ☐ No
How would you prefer to approach these experiences?	☐ Share a brief note
	☐ Explore together when ready
	☐ Skip for now
Current impacts:	☐ Body ☐ Emotions ☐ Patterns
If sharing:	

SECTION 10 — MEDICAL + LEGAL CONTEXT

This helps me understand any current factors that may influence your safety, comfort, or participation in sessions.

Current medications: _____

_____

Medical conditions or chronic illnesses: _____

_____

_____

Legal involvement (if any): _____

_____

_____

INITIAL HERE _____

SECTION 11 — SUPPORTS + STRENGTHS

This helps me understand the resources and capacities you already have in your life.

Who or what supports you?

☐ Family ☐ Friends ☐ Partner ☐ Pets/animals ☐ Limited support

Other: _____

Personal strengths you'd like me to know about:_____

_____

_____

SECTION 12 — COMMUNICATION PREFERENCES

Preferred contact method:	☐ Phone ☐ Text ☐ Email ☐ No preference
Do you prefer that I do NOT leave voicemail or text messages?	☐ Yes ☐ No
If I am concerned for your safety and I cannot reach you, may I contact your emergency contact?	☐ Yes ☐ No

SECTION 13 — ACKNOWLEDGMENT

I understand the purpose of this intake form and that my responses will help guide our work.

Signature: _____ Date: _____

Thank you for the time it took to complete this form. Your input is vital to our success!

INITIAL HERE _____