

Healing Sessions

Facilitated by Dr. Joy Lovesey

CONFIDENTIAL QUESTIONNAIRE

Note: All information will be kept strictly confidential except that which I am legally obliged to report, such as a threat of injury to yourself or others. If you are uncomfortable in any way with any of these questions, you can skip them, except those marked with \* which are essential. The more you can tell me about yourself, the more I may be of assistance to you. Feel free to use more paper/space to go into detail about any issue you wish me to know about you, or to help you with. Please complete and return it to me ahead of your first session by email to drjoylovesey@myhealingspace.org.

Name:\*

Date of Birth: Age:

Address:\*

Phone number(s):\*

Email:

Relationship Status:

Name of Spouse/Partner:

Names and Ages of Children:

Emergency contact name:\*

Relationship to you:

Contact number(s):\*

Name and address of GP:\*

Name and relationship to those you share a household with:

Sources of support, and reliability of support currently in your life:

What is your current occupation?

Do you enjoy your work?

Have you received a mental health diagnosis, or do you have concerns about your current mental health?\*

Are you currently under the care of a mental health practitioner, undergoing therapy, or undertaking any other holistic practices? Please give details, such as which modality, how long this has been occurring, and how frequently.\*

What therapy or therapeutic practice have you done previously. Please give details such as length, purpose, modality, and frequency, along with if and how it helped, and why it ended.

List any current health problems:

Is a doctor treating you?

If yes, please list:

List any medications you are currently taking:\*

List your three most important lifetime goals:

1.

2.

3.

List your three favourite hobbies:

1.

2.

3.

What is your greatest dream for yourself?

Why are you seeking therapeutic work with me at this time?\*

If there could be a miraculous outcome from your healing, what would it be?

Consider any issues you would like to bring to the session for healing, for which you would like improvement or relief. This could be anything, e.g. anxiety, insomnia, stress, trauma, relationship problems, abuse recovery, addictions, etc. Please rate your current symptoms on a scale of 1-10 with 1 being virtually no symptoms and 10 being the worst imaginable. Also the frequency and duration of the problem, and how it affects your life.

Example:

Problem – I find it hard to sleep.

Frequency – every night,

Duration – it takes me hours to fall asleep

Impact – I am demotivated in life and lethargic at work

Severity of problem – 9/10

Without the problem I would – have lots of energy and be much happier to be involved in everything.

1

Problem

Frequency

Duration

Impact

Severity

Without this I would

2

Problem

Frequency

Duration

Impact

Severity

Without this I would:

3

Problem

Frequency

Duration

Impact

Severity

Without this I would:

If you have a specific problem, please note what was happening in your life around the time it started (if you know).

What is, or was, the emotional and psychological health of your parents?

What is your current relationship like with family members?

Do you follow any religious or spiritual practices or meditation?

Please list any other conditions occurring in your life that you believe are negatively affecting you in any way. Use as much space as you like to tell me the details of your concerns, needs or fears.

Answer each of these question according to the way you personally feel, using the following scale:

**1 2 3 4 5 6 7
Not at All Moderately Extremely**

\_\_\_\_ 1. Are you easily overwhelmed by strong sensory input?

\_\_\_\_ 2. Do you seem to be aware of subtleties in your environment?

\_\_\_\_ 3. Do other people's moods affect you?

\_\_\_\_ 4. Do you tend to be more sensitive to pain?

\_\_\_\_ 5. Do you find yourself needing to withdraw during busy days, into bed or into a darkened room or any place where you can have some privacy and relief from stimulation?

\_\_\_\_ 6. Are you particularly sensitive to the effects of caffeine?

\_\_\_\_ 7. Are you easily overwhelmed by things like bright lights, strong smells, coarse fabrics, or sirens close by?

\_\_\_\_ 8. Do you have a rich, complex inner life?

\_\_\_\_ 9. Are you made uncomfortable by loud noises?

\_\_\_ 10. Are you deeply moved by the arts or music?

\_\_\_ 11. Does your nervous system sometimes feel so frazzled that you just have to go off by yourself?

\_\_\_ 12. Are you conscientious?

\_\_\_ 13. Do you startle easily?

\_\_\_ 14. Do you get rattled when you have a lot to do in a short amount of time?

\_\_\_ 15. When people are uncomfortable in a physical environment do you tend to know what needs to be done to make it more comfortable (like changing the lighting or the seating)?

\_\_\_ 16. Are you annoyed when people try to get you to do too many things at once?

\_\_\_ 17. Do you try hard to avoid making mistakes or forgetting things?

\_\_\_ 18. Do you make a point to avoid violent movies and TV shows?

\_\_\_ 19. Do you become unpleasantly aroused when a lot is going on around you?

\_\_\_ 20. Does being very hungry create a strong reaction in you, disrupting your concentration or mood?

\_\_\_ 21. Do changes in your life shake you up?

\_\_\_ 22. Do you notice and enjoy delicate or fine scents, tastes, sounds, works of art?

\_\_\_ 23. Do you find it unpleasant to have a lot going on at once?

\_\_\_ 24. Do you make it a high priority to arrange your life to avoid upsetting or overwhelming situations?

\_\_\_ 25. Are you bothered by intense stimuli, like loud noises or chaotic scenes?

\_\_\_ 26. When you must compete or be observed while performing a task, do you become so nervous or shaky that you do much worse than you would otherwise?

\_\_\_ 27. When you were a child, did parents or teachers seem to see you as sensitive or shy?

Are you currently experiencing any of the following? (Please **highlight** all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Social anxiety | Teeth grinding | Eating disorder | Bereavement  |
| Inability to relax | Poor health | Co-dependency | Fatigue |
| Insomnia | Alcohol abuse | Inability to focus attention | Low self-esteem |
| Depression | Drug abuse | Autism | ADD / ADHD  |
| Self-harm | Cigarette smoking | Relationship problems | Abusive home situation |
| Nightmares | Overeating | Recent divorce/ breakup | Abusive work situation |
| Sexual issues | Compulsive tendencies | Childhood trauma | Grief |

You may or may not have explored systems of personality such as these – if you have, then you can include this info so I can learn better how I might help you. If you haven’t but are interested to find out, please ask me for links where you can take free online tests. This information is not essential so it’s ok to leave it all blank if you don’t know!

Enneagram type (and/or tritype):

Myers Briggs personality type:

Human design type:

|  |
| --- |
| **RELEASE STATEMENT**I hereby give permission for DR. JOY LOVESEYto do everything reasonable in her ability to help me to heal myself for the purposes outlined in this intake form, and for future purposes that I may request. I understand that this will not involve any medical procedure and that no medical benefits are being offered to me. I understand that the results of the healing sessions are contributed to by my own serious participation, my desire and willingness to engage, and other factors outside of the realm of control, and that Joy cannot offer any guarantee of the outcome. I have been informed that Joy is not offering any diagnosis or cure for any condition, and that I am responsible for ensuring I work under the guidance of medical professionals where necessary. I agree that I am responsible for my own wellbeing, and will seek additional therapeutic support when needed.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |