

Intake form Haptomotion

1. What do you need help with?

2. Do you have any symptoms (physical / psychological / emotional)? yes no
If so, what are they?

Since when have you been experiencing these symptoms?

3. Which doctors have you consulted? general practitioner specialist

psychiatrist

Has a diagnosis been made?

yes no

Who made the diagnosis?

general practitioner specialist

psychiatrist

What diagnosis has been made?

4. Have you been treated for this problem before? yes no

If so, by whom?

5. What is the result of the treatment followed so far?

The questionnaire will continue the following page.

Amsterdam
Niasstraat 5G
1095 TS Amsterdam

MA 08:00 - 19:00
DI 08:00 - 19:00
WO 08:00 - 13:00
DO 08:00 - 19:00

Muiden
Burg. de Raadsingel 3
1382 BE Muiden

WO 14:00 - 18:00
VR 08:00 - 18:00

6. Are you currently undergoing medical / psychological / psychiatric treatment?

yes no

If so, by whom?

7. Are you taking any medication? yes no

If so, which one(s)?

Prescribed by:

general practitioner specialist

psychiatrist

8. What do you want to achieve with the therapy?

9. Additional information that may be relevant to the treatment:

Date:

Place:

Name therapist:

Name cliënt:

Signature therapist

Signature client

(in case of a minor, one of the parents or legal guardian)