



# OUTRIGHT EXPOSURE INTAKE FORM

NAME \_\_\_\_\_ DATE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY STATE ZIP \_\_\_\_\_

PHONE HOME \_\_\_\_\_ MOBILE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ GENDER \_\_\_\_\_

HEALTH CONDITION \_\_\_\_\_ (POOR, FAIR, GOOD, EXCELLENT)  
HEALTH CONTINUED: ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

WHAT ARE YOU BEING TREATED FOR? \_\_\_\_\_

CURRENT PHYSICIAN PROVIDING TREATMENT  
NAME \_\_\_\_\_ PHONE \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES OR HEALTH CONDITIONS WE SHOULD KNOW ABOUT?

WHAT ARE YOUR HOBBIES?

PLEASE TELL US WHAT IF ANY PROFESSIONAL MENTORING RELATIONSHIPS OR PROGRAMS YOU HAVE PARTICIPATED IN THE PAST 12 MONTHS. (PSYCHOTHERAPY, COACHING, TUTORING, OUTWARD BOUND ETC.)

HOW DO YOU FEEL ABOUT THOSE EXPERIENCES?

PLEASE TELL US WHY YOU WANT TO PARTICIPATE IN THIS PROGRAM OUTRIGHT EXPOSURE?



