

Intake Form

PERSONAL DETAILS:

Surname: _____ Forename: _____

Preferred name: _____

Age: _____ Date of Birth: _____

Address: _____

Marital/Relationship Status: _____ Occupation: _____

Email address: _____ Telephone: _____

Emergency contact name and telephone number: _____

HEALTH:

Doctor's name and address: _____

Date of last check up: _____

Medications being taken: _____

HEALTH PROBLEMS (past & current):

FROM THE LIST BELOW CIRCLE/TICK YOUR AREAS OF CONCERN:

Addictions Drinking Smoking Drugs Gambling Compulsive Behaviour	Anxiety Stress Fears Phobias Panic Attacks Guilt Relaxation	Eating Problems Food /Diet Weight Problems Anorexia Bulimia Exercise	Depression Confidence Self Esteem Motivation Achieving Goals Procrastination
Career Issues Interview Skills Nerves Public Speaking Concentration Exams Memory Driving Skills	Sexual Problems Fertility IVF Conception Pregnancy Birth	Pain Control Hearing Sight/Vision Mobility Skin Problems Hair Growth	Relationships Childhood Problems Sleep Problems