Intake and Consultation Form

PERSONAL DETAILS:

Surname: Forename:

Preferred name / Pronoun: Age:

Address:

Relationship Status: Occupation:

Email address: Telephone:

Emergency Contact Name: Emergency Contact Telephone:

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 Behavior	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	Pain Control Hearing Sight/Vision Mobility Skin Problems Hair Growth	Relationships Childhood Problems Sleep Problems	Other: Please describe

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