Intake & Consultation Form

PERSONAL DETAILS:

Surname: Forename:

Preferred Name: Date of Birth:

Address:

Relationship Status: Occupation:

Email Address: Telephone Number:

Emergency Contact Name: Telephone Number::

HEALTH:

Doctor's Name and Address:

Medication:

HEALTH PROBLEMS/Medical Conditions (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

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INTAKE	NOTES
PP **Presenting Problem** Briefly describe the problem(s) you want to address. Which is the most urgent or priority for you to treat.	
STH **Symptoms/ Triggers/Habits:** What happens to you or you feel when the problem to be treated appears.	
CH – Childhood Describe what your childhood has been like. The relationship with parents and siblings. Any other situation you'd like to share.	
WYW **What you Want** How do you want to feel, behave, think, to get, to achieve, ...	
LWTP **Life Without the Problem** Imagine that you have done the session and everything has gone great and you no longer have that problem. What will your life be like without that problem?	