Intake & Consultation Form

PERSONAL DETAILS:

Surname: ______________________ Forename: ______________________

Preferred Name: ______________________ Date of Birth: ______________________

Address: ____

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Relationship Status: ______________________ Occupation: ______________________

Email Address: ______________________ Telephone Number: ______________________

Emergency Contact Name: ______________________ Telephone Number:: ______________________

HEALTH:

Doctor's Name and Address: ____

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Medication: ____

HEALTH PROBLEMS/Medical Conditions (Past & Current):

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

Addictions Drinking Smoking Drugs Gambling	Anxiety Stress Fears Phobias	Eating Problems Food /Diet Weight Problems Anorexia Bulimia	Depression Confidence Self Esteem Motivation

Compulsive Behaviour	Panic Attacks Guilt Relaxation	Exercise	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