INITIAL CONSULTATION FORM

PLEASE NOTE: All information will be kept strictly confidential except that which I am legally obliged to report, such as a threat of injury to yourself or others. If you are uncomfortable in any way with any of these questions, feel free to skip them. Please be aware that the more you can tell me about yourself, the more I may be of assistance to you. Feel free to use more paper to go into detail about any issue you wish me to know about you, or to help you with. Please complete and sign the form prior to your first session.

PERSONAL DETAILS:			
Full Name:			
Date of Birth:	Age:	Gender: M/F*	
Address: (including Post Code)			
Home Telephone:	Mobile Number:	Work Number:	
Which of these numbers is it best to use to contact you?		Home/Mobile/Work*	
Can I leave a voicemail or message on your preferred contact number?		Yes/No*	
Email address:			
Would you like to be kept informed of offers, promotions, relevant information via an e-newsletter?		Yes/No*	
Occupation:			
Marital Status:	Single/Engaged/Married/Widowed/Divorced/Living with Partner/Civil Partnership*		
Name of spouse/partner:			
Are they aware that you are seeing Reflective Wellbeing?		Yes/No*	
Children: (name & age)			
Emergency Contact Name:			
Contact Number:	Relationship to you:		

(* please delete as appropriate)

Please answer the following questions thoroughly and honestly

GP DETAILS:	
GP Name:	
GP Address: (including Post Code)	
GP Telephone Number:	
Are you happy for your GP to be contacted if required? (please note that you will be told beforehand if this is necessary)	Yes/No*
I give my permission and consent to my GP being contacted to seek medical consent prior to me receiving hypnotherapy, and understand that I will be notified of this beforehand.	
Signed:	
Full Name: (please PRINT)	
Date:	

MEDICAL HISTORY:			
Please indicate if you suffer from, have suffered from or are being investigated for any of the following conditions.			
High Blood Pressure:	Yes/No*	ADHD:	Yes/No*
Low Blood Pressure:	Yes/No*	Phobias:	Yes/No*
Anxiety:	Yes/No*	Autism:	Yes/No*
Depression:	Yes/No*	Heart condition:	Yes/No*
Post Natal Depression:	Yes/No*	Diabetes:	Yes/No*
Lack of confidence	Yes/No*	Cancer:	Yes/No*
Lack of self-esteem	Yes/No*	Epilepsy:	Yes/No*
Stress:	Yes/No*	Pain condition:	Yes/No*
Panic Attacks:	Yes/No*	Sleep problems:	Yes/No*
Compulsive Disorders:	Yes/No*	Migraines:	Yes/No*
Psychosis:	Yes/No*	Genetic condition:	Yes/No*
BiPolar Disorder:	Yes/No*	Thyroid problems:	Yes/No*
Schizophrenia:	Yes/No*	Overweight:	Yes/No*
PTSD:	Yes/No*	Underweight:	Yes/No*
Neurosis:	Yes/No*	Other:	Yes/No*
Height:	cms/in*	Weight:	kg/lbs*
Are you pregnant?	Yes/No*	If, Yes, when is your due date?	
Smoking Status:	Yes/No*	How many cigarettes do you smoke a day?	
Do you drink alcohol?	Yes/No*	How many units do you drink a day?	
Where you have indicated Yes or Other, please can you provide more details:			

MEDICATION:			
Please can you provide details of any medication that you are taking.			
Name of medication	Dose e.g. 100mg	Frequency e.g. twice a day	Condition it treats

FAMILY MEDICAL HISTORY:			
Please provide details of your family medical history.			
BP:	Yes/No*	Heart Condition:	Yes/No*
Cancer:	Yes/No*	Diabetes:	Yes/No*
Mental Health Disorder:	Yes/No*	Other:	Yes/No*
Where you have indicated Yes or Other, please can you provide more details:			

HOW DID YOU HEAR ABOUT US:
Internet search/Website/Friend/Work Colleague/Advertisement/Other*
If, Other, please state:

TERMS AND CONDITIONS:

I agree that all the information I have provided is true.

I give my consent for you to contact my GP for medical consent, if appropriate.

I understand that if I arrive for treatment under the influence of alcohol and/or drugs, I will NOT receive the session and I will be charged in full.

I understand that payment must be made in full 48 hours before the day of the appointment.

I understand that if I arrive late, I will only receive hypnosis for the time remaining and will still be charged the full fee.

I agree to give 48 hours' notice if I need to cancel my appointment, if not the full fee is payable.

I understand that if I fail to turn up for an appointment I will be liable for the full fee.

I understand that all the information I have given on this form will be held in a safe and secure place.

I agree to all of the above Terms and Conditions.

Signed:

Print Name:

Date:

PLEASE COMPLETE AND RETURN TO REFLECTIVE WELLBEING

REFLECTIVEWELLBEING@GMAIL.COM