Personal Details
First Name: ______________________________Last Name:________________________
Preferred name: _________________Age: ______Date of Birth: __________________
Address: ______________________________________________________________________
Relationship status: _________________Occupation: ____________________________
Email address: ______________________________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:__________

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