**Dream CBT**

**Cognitive Behavioural Therapy**

**THIS DOCUMENT IS PRIVATE AND CONFIDENTIAL**

**The following information is required for your safety and to benefit your health. There may be certain contraindications, which will require special attention and/or further discussion.**

It may be necessary to consult with medical practitioners before any treatment can be given. The following details will be treated with the strictest confidence.

Client’s name:

Address:

Contact Number:

Email Address:

Profession:

Sex: Male Female

Date of Birth:

Marital Status: Single Married Divorced Widowed Co-habiting

No. & Age of Children:

**Female Only:**

Pregnant: N/A No Yes How Many Months?

Have You Recently Experienced a Miscarriage or Termination?

Are You Currently Menstruating?

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Parents & Sibling Health History:

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GP Name & Address:

Medical History/Operations:

Medication/Current Health:

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Recreational Drugs You Are Taking:

Recreational Drugs You Have Previously Taken:

Alcohol Intake: Daily Weekly Infrequently

Date Of Last Drink

Do You Smoke/Vape? **YES NO**

If So, How Often:

Do You Have Food Allergies: **YES** **NO**

Do You Suffer from Indigestion or Heartburn: **YES NO**

Do You Have Food Allergies:

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Do you suffer from any of the following **(please circle):**

**Muscular/Skeletal Problems**: Neck – Back - Aches & Pains - Stiff joints – Headaches – Rheumatism - Arthritis

**Digestive Problems**: Constipation – Diarrhoea – Bloating - Liver/gall bladder - Stomach - Diabetes

**Circulation**: Heart problems - Blood pressure – Fluid Retention – Tired Legs – Varicose Veins – Cellulite – Kidney Problems – Cystitis – Cold Hands & Feet

**Gynaecological**: Irregular periods – PMT – Menopause – HRT – Pill - Coil

**Nervous System**: Sensitive - Migraine – Tension – Depression – Epilepsy

**Immune System**: Prone to Infections – Sore Throats – Colds – Chest – Sinuses – Regular Antibiotics Taken

Have You Ever Been Diagnosed with Cancer: **YES NO**

If Yes, Details:

Ability To Relax: **GOOD AVERAGE POOR**

Hobbies Or Creative Interests:

Do You Exercise: **NONE OCCASIONAL IRREGULAR. REGULAR**.

Type Of Exercise:

Sleep Patterns: **GOOD AVERAGE POOR** Hours Of Sleep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Have Daylight Access at Work: **YES NO**

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Do You Suffer From: **NERVOUS TENSION DEPRESSION ANXIETY**

On A Scale Of 1 – 10, How Stressful Is Your Life Currently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On A Scale Of 1 – 10, How Stressful Is Your Work Life Currently: \_\_\_\_\_\_\_\_\_\_\_\_

Are You Currently Experiencing Major Stressors in Your Life e.g.:

Bereavement, Divorce, Birth, Marriage, Moving House, Changing Jobs, Personal or Family Illness etc: **YES NO**

Do You Eat Regular Meals: **YES NO**

Do You Eat in A Hurry: **YES NO**

Do You Take Food Supplements: **YES NO**

Do You Have a Healthy Diet**: YES NO**

How Much of Each of These Does Your Diet Contain:

Fresh Fruit

Fresh Vegetables

Protein (Source):

Dairy Produce:

Sweet Things:

Added Salt:

Added Sugar:

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How Many Daily Drinks: Tea: Coffee: Energy Drinks:

Fruit Juices: Soft Drinks: Fizzy Drinks: Water:

Do You Suffer from Dermatitis: **YES NO** Acne: **YES NO** Eczema: **YES NO**

Psoriasis: **YES NO** Allergies: **YES NO** Hay Fever: **YES NO** Asthma: **YES NO**

Have You Ever Had Any Form Of Therapy Previously: **YES NO**

If Yes, What Type & For What Reason?

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Is There Anything Relating To Your Health Or Requirements That You Would Like The Therapist To Be Aware Of:

Any Other Information:

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_