**Dream CBT**

**Cognitive Behavioural Therapy**

**THIS DOCUMENT IS PRIVATE AND CONFIDENTIAL**

**To be completed on behalf of a child or young person**

**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: Parent/Guardian Name:

Address:

Sex: Male Female

Date of Birth:

Height:

Weight:

Contact Number of Parent/Guardian:

GP Name & Address:

Parental History:

Medical history/operations:

Medication/present health:

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

Neck. Back. Aches. Pains. Stiff joints. Headaches. Heart problems. Blood pressure.

Constipation. Diarrhoea. Bloating. Liver/gall bladder. Stomach. Diabetes

Cystitis. Cold hands and feet. Irregular periods. PMT. Migraine. Tension. Depression.

Epilepsy. Prone to infections. Sore throat. Colds. Chest problems. Sinus problems.

Have you ever been diagnosed with cancer? **Yes**  **No**

If yes, details:

Ability to relax: **Good Poor Average**

Time to relax: Hobbies or creative interests?

Do you exercise? **None Occasional Irregular Regular**

Type of exercise?

Sleep patterns: Good Poor Average Number of hours per night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from: **Nervous Tension Depression Anxiety**

On a scale of 1 – 10 (10 being the most stressed), how stressful would you say your life is?

Do you eat regular meals? **Yes No**

Do you take food or vitamin supplements? **Yes No**

Do you have a healthy diet? **Yes No**

How much of these foods does your diet contain?

Fresh fruit:

Fresh vegetables:

Protein:

Dairy products:

Sweet things:

Added salt:

Added sugar:

How many drinks per day?

Tea\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coffee\_\_\_\_\_\_\_\_\_\_\_\_\_

Fruit juice\_\_\_\_\_\_\_\_\_\_\_\_ Water\_\_\_\_\_\_\_\_\_\_\_\_\_

Soft drinks\_\_\_\_\_\_\_\_\_\_\_ Fizzy drinks\_\_\_\_\_\_\_\_\_

Do you suffer from food allergies? **Yes No**

Overeating/binge eating? **Yes No**

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/treatment previously? **Yes No**

If yes, what type and reason?

Is there anything related to your health or requirements that you would like the therapist to be aware of?

Any other information: