Intake Form

PERSONAL DETAILS:

Surname: Forename:

Preferred name:

Age: Date of Birth:

Address:

Marital/Relationship Status: Occupation:

Email address: Telephone:

Emergency contact name and telephone number:

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:

☐ Addictions ☐ Drinking ☐ Smoking ☐ Drugs ☐ Gambling ☐ Compulsive Behaviour	☐ Anxiety ☐ Stress ☐ Fears ☐ Phobias ☐ Panic Attacks ☐ Guilt ☐ Relaxation	☐ Eating Problems ☐ Food /Diet ☐ Weight Problems ☐ Anorexia ☐ Bulimia ☐ Exercise	☐ Depression ☐ Confidence ☐ Self Esteem ☐ Motivation ☐ 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

INTAKE	NOTES
STH Symptoms/ Triggers/ Habits:	
CH Childhood	
WYW What you Want / Magic Wand	
LWP Life Without the Problem	