Intake and Consultation Form

PERSONAL DETAILS:

First Name: Last Name:

Preferred name: Date of Birth:

Address:

Relationship Status: Occupation:

Email: Phone:

Emergency Contact Name: Emergency Contact Phone:

HEALTH:

Doctor's name and address:

Date of last check up:

Medications being taken:

HEALTH PROBLEMS: (past & current):

FROM THE LIST BELOW PUT A CHECK BY 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