# Intake & Consultation Form

## PERSONAL DETAILS:

Surname: Forename:

Preferred Name: Date of Birth:

Address:

Relationship Status: Occupation:

Email Address: Telephone Number:

Emergency Contact Name: Telephone Number::

## HEALTH:

Doctor’s Name and Address:

Medication:

**HEALTH PROBLEMS/Medical Conditions** (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 |

# Session Notes Plan

|  |  |
| --- | --- |
| **INTAKE** | **NOTES** |
| **PP**  Presenting Problem |  |
| **STH**  Symptoms/ Triggers/Habits: |  |
| **CH**  Childhood |  |
| **WYW**  What you Want |  |
| **LWTP**  Life Without the Problem |  |

|  |  |
| --- | --- |
| **RTT SESSION NOTES PLAN** | |
| **Scene 1** | Beliefs / Feelings to be reframed |
| **Scene 2** |
| **Scene 3** |
| **LH/RH** *(Link back to Presenting issue)* | Language for Transformation |
| **R *because***  **F *because***  **P *because***  **I *because*** |

