Celestine R. Wussler

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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