

Client Registration

**Strictly Confidential**

Name

Address

Phone number

Email

Date of Birth

Status married/single/divorced/partnered

Partner's name

Children yes/no

Names and ages

Occupation

Employer

Do you take any exercise? YES/NO (if yes please give details).

GP Name & Surgery Address

How did you hear about me?

Do you have any current medical conditions?

Have you had treatments from a psychiatrist, psychologist, therapist or counsellor?

If yes, when and what for?

Any other medical information that you may deem appropriate

Are you taking any Medication or Drugs? YES/NO (if yes please give details)

Briefly - What is the reason for your consultation?

How long have you had this problem/issue?

On a scale of 0-10 – how does this disrupt your life?

Can you pin point the cause?

How does it affect you?

Physical symptoms

Emotional symptoms

Please complete the Tick chart below.

If you answer yes to a question please give it a score out of 1-5.

E.g. the symptom/s being at best –1 and at worst –5.

	Yes	No
Any insecurities		
Low self esteem		
Lack of confidence		
Disturbed sleep or insomnia		
Mood swings		
Depression		
Anxiety		
Lack of concentration		
Stress		
Tension headaches		

What are you hoping to achieve from receiving therapy?

How would you like to conduct your session? Please tick

Visit my practice in West Chiltoningon, RH20 2QY.

Home visit

Skype – number

Voice call

Face-Time

other ?

Details of person to contact in case of emergency -  
(only needed if you are visiting my practice)

**Signature**

**Print name**

**Date**