APPENDIX: FULL INTAKE FORM

PERSONAL DETAILS:

Surname: Forename:

Preferred name:

Age: Date of birth:

Address:

Relationship status: Occupation:

Email address: Telephone:

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 behavior	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

INTAKE	NOTES
PP PRESENTING PROBLEM	
STH SYMPTOMS/ TRIGGERS/HABITS	
CH CHILDHOOD	
WYW WHAT DO YOU WANT?	
LWTP LIFE WITHOUT THE PROBLEM	