MIND GAME CHANGER

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):

Do you or have you had any of the following:

- Auditory/visual hallucinations
- Epilepsy
- Dissociative disorders
- Personality disorders
- Psychosis
- Schizoaffective disorder
- Schizophrenia

MIND GAME CHANGER

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