the inner shine clinic

THE INNER SHINE CLINIC CLIENT INFORMATION FORM - ADULT

CONFIDENTIAL

NAME: _____ DOB: _____ SEX: _____

MARITAL STATUS: _____ SINGLE _____ MARRIED _____ DEFACTO _____ DIVORCED _____ SEPARATED _____ WIDOWED _____ REMARRIED

PHONE: _____

PRESENTLY LIVING WITH: _____

FAMILY NUMBER TO CONTACT IN CASE OF EMERGENCY: _____

DO YOU GIVE CONSENT FOR THE INNER SHINE CLINIC TO LEAVE YOU A MESSAGE OR TEXT ON THIS NUMBER? : YES/NO

EMAIL: _____

ADDRESS: _____

_____

How did you find out about the Inner Shine Clinic: _____

_____

Do you have any health conditions: _____

_____

Are you pregnant: YES/NO

Are you currently taking any medications or supplements? : YES/NO

If so what are you taking and what for? _____

_____

Are you currently under the treatment of a psychiatrist, psychologist or doctor? _____

Any other health care professional you are seeing eg. Chiropractor, Therapist? _____

Physiotherapist, Dietician? _____

Are you currently using alcohol and/or drugs to help you unwind? YES/NO

Please indicate _____

If yes, which and how frequently? _____

In your own words, briefly describe the main problem that prompted you to seek Integrative Counselling/Wellbeing Coaching or EFT at this time:

_____

_____

Any other current challenges in your life we should be aware of: _____

_____

_____

Strengths and resources that support you when times are challenging: _____

_____

_____

List your five main fears:

1. _____

2. _____

3. _____

4. _____

5. _____

PROBLEMS AREAS: IN THE FOLLOWING LIST, PLACE A CHECK MARK NEXT TO EACH ITEM THAT IDENTIFIES AN AREA OF CONCERN TO YOU.

__ ANGER

__ CANNOT CONCENTRATE

__ STRESSED/OVERWHELMED

__ ANXIETY

__ DEPRESSION

__ WEIGHT/BODY ISSUES

__ FEELINGS OF INFERIORITY

__ FEARLFULNESS

__ PHOBIAS

__ FINANCIAL PROBLEMS

__ LONELINESS

__ MARITAL/RELATIONSHIP PROBLEMS

__ MEMORY PROBLEMS

__ GRIEF/LOSS

__ PAST TRAUMA/PAINFUL MEMORY

__ PROBLEMS WITH CHILDREN

__ SELF ESTEEM

__ SLEEP PROBLEMS

__ CHRONIC PAIN

__ TROUBLE MAKING DECISIONS

__ UNABLE TO RELAX

__ UNHAPPY MOST OF THE TIME

__ USE OF ALCOHOL/DRUGS

__ USE OF ALCOHOL/DRUGS BY FAMILY MEMBER

__ WORK

__ WORRY

__ OTHER (SPECIFY)

_____

_____

Expectations for Counselling/Coaching/EFT session:_____

_____

_____

What about your present situation/behaviour do you want to change? _____

_____

_____

What feelings do you want to alter (ie. Increase or decrease) _____

_____

_____