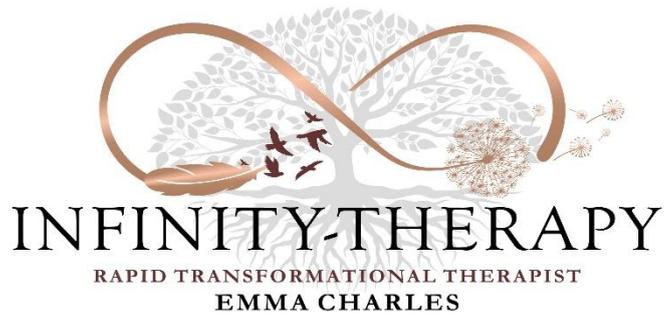


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Intake and Consultation Form

PERSONAL DETAILS:

Surname: _____ Forename: _____

Preferred name: _____ Date of Birth: _____

Address: _____

Relationship Status: _____ Occupation: _____

Email address: _____ Telephone: _____

Emergency Contact Name: _____ Emergency Contact 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:

Addiction s 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/ Visio n Mobility Skin Problems Hair Growth	Relationships Childhood Problems Sleep Problems

Session Notes Plan

INTAKE	NOTES
PP Presenting Problem	
STH Symptoms/ Triggers/Habits:	
CH Childhood	
WYW What you Want / Magic Wand	
LWP Life Without the Problem	

RTT SESSION NOTES PLAN

Scene 1	Beliefs / Feelings to be reframed
Scene 2	
Scene 3	
LH/RH (<i>Link back to Presenting issue</i>)	Language for Transformation
R _____ <i>because</i> _____	
F _____ <i>because</i> _____	
P _____ <i>because</i> _____	
I _____ <i>because</i> _____	