CONSCIOUS beginnings

CONFIDENTIAL CLIENT INFORMATION

First Name		Last Name	
Address			
Suburb		State / Post Code	
Home Phone		Mobile	
Email		Date of Birth	/ /
Occupation		Marital Status	

Reason for seeking counselling: . . . . . .

. . . . . .

What, if any, significant medical problems do you have? . . . . . .

. . . . . .

What, if any, medications are you currently taking? (Name, dose, for what condition) . . . . . .

. . . . . .

Any personal history of hospitalization or other treatment for mental health? (Please list dates, locations and reasons)

. . . . . .

How did you find about Conscious Beginnings or who referred you? . . . . . .

If referred, name of the G.P. or Therapist: . . . . . .

If you were referred by your Doctor or therapist, do you give me permission to communicate with them about our work together? ☐ Yes ☐ No

Would you like to subscribe to my mailing list for information, tips and latest research on therapies? (I will never share your email and you may unsubscribe at any time) ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Address: _____

Home Phone: _____ Mobile: _____

In an emergency, I agree to allow Conscious Beginnings to call the above person/s to inform them of my condition and the need for assistance. I also agree to have emergency assistant provided by an outside agency if necessary.

Signature: Date: