TOGETHERNESS THERAPY	Date:
Client Name:	
Any Nickname	
Address:	
Postcode:	
Tel No:	
Occupation:	
E-mail address:	
Skype Address:	
Facebook:	
Age:	
Date of Birth:	
Relationship (Married/Divorced/Separated/Single/Co-habiting etc.)	
Partner's Name:	
Children: (names and ages):	
Religious/Spiritual Beliefs:	
Describe your childhood using one word (eg, happy, sad, exciting, contented etc**)**	
What is your favourite colour?	
Parents Names:	
Alive ☐ **Deceased** ☐	
Brothers/Sisters (names and ages)**:**	
Have you been hypnotised before? Yes ☐ **No** ☐ Don't **know** ☐	
If **YES** please provide details:	
What benefits are you expecting?	
How will you know when you will no longer require my help?	
Who supports what you are doing?	
How did you find out about my services? Referred by Friend ☐ Website ☐ Leaflet ☐ Business Card ☐ Other ☐ (please state)	
Do you want to be here? Yes ☐ No ☐	
Was it some else's idea? Yes ☐ No ☐	
Who is paying for your therapy? Me ☐ Someone else ☐	
How many years have you had this issue?	
What makes it worse?	
Any other therapies tried at all. If so what?	
How often would you be willing to come for sessions?	
Weekly ☐	
Fortnightly ☐	
Monthly ☐	

Other ☐ (tick the most appropriate)
On a scale of 1- 10 how committed are you to resolving this issue(s)? (10 being most committed)
What do you do to relax?
Do you sleep OK? (If not explain why) Yes ☐ No ☐
How many hours sleep do you get each night?
Name of GP:
Address:
In some cases I will contact your GP. Do you give permission? Yes ☐ No ☐
Medical Condition: (have you ever had any of these medical conditions, tick as appropriate) Epilepsy ☐ High/Low Blood Pressure ☐ Head Injuries ☐ Mental Illness ☐ Heart problems ☐ Depression ☐ Migraines ☐ Stress ☐ Irritable Bowel Syndrome ☐ Diabetes ☐ Any other condition (please describe):
Medication: Yes ☐ No ☐ (please state if applicable)
The following are a list of activities you may or may not participate in. Please take some time to provide a score based on whether you enjoy taking part in the activity. A score of 10 means that you really enjoy the activity and a score of 0 means that you don't take part in the activity. Please provide a score of between 10 – 0.

Subject/Activity	Rating out of 10	Subject/Activity	Rating out of 10
Lifts/Elevators		Keep Fit	
Walking/Countryside		The Beach	
Acting in a play		Bird watching	
Drinking Alcohol		Singing	
Sunshine		Dogs	
Cats		Camping	
Holidays		Playing cards	
Horse racing		Cooking	
Taking Drugs		Dancing	
Sport		Eating	
Pubs		Music	
Sudoku		TV	
Jigsaw Puzzles/Crosswords		Reading	

Do you have any known fears or phobias? (Tick as appropriate - the Practitioner may be able to provide solutions to addressing these if in agreement)
Anxiety ☐ Addiction ☐ Weight loss ☐ Smoking ☐ Flying ☐ Panic Attacks ☐ Alcohol Abuse ☐ Food Addiction ☐ Gambling ☐ Depression ☐ Insomnia ☐ Sleep disorder ☐ Drug Abuse ☐ Pain ☐ Sexual Issues ☐ Stress ☐ Low self esteem ☐ Relationship Issues ☐ Low self confidence ☐ Public Speaking ☐ Anger Management ☐ Post Traumatic Stress Disorder (PTSD) ☐ Exam nerves ☐
Would you be willing to know more about overcoming the issues you have ticked above? Yes ☐ No ☐

I am willing to undertake any therapy that is required to allow me to address any issues that I may be experiencing. I understand that the information provided on this form will be treated in the strictest confidence and will only be used as part of any therapy that is provided by the Practitioner. If I do disclose any information, which may potentially harm myself or anyone else I am aware that this will be reported to the appropriate authorities. I agree to this information being used for promotional and marketing purposes.

Name: Signature: Date: