CONFIDENTIAL

LIFE COACHING INFORMATION FORM

CLIENT DETAILS:

Name: .....

Address: .....

.....

.....

Post Code: .....

D.O.B: .....

Occupation .....

Where did you hear about us?

.....

Sex: .....

Telephone: .....

Mobile: .....

email: .....

Doctor:

Name: .....

Telephone: .....

Address: .....

.....

What is your primary reason or goal for today's visit? _____

Please tick all that **apply to you.**

☐ ANXIETY / STRESS	☐ PHOBIC REACTIONS
☐ INSOMNIA	☐ RELATIONSHIP ISSUES
☐ CHRONIC PAIN	☐ SMOKING
☐ DEPRESSION	☐ SPORTS PERFORMANCE
☐ WEIGHT ISSUES	☐ ALCOHOL / DRUG USE
☐ SURGICAL ANXIETY	☐ TEST ANXIETY
☐ GENERAL FEARS	☐ UNWANTED HABITS
☐ LACK OF MOTIVATION	☐ GOAL SETTING
☐ LOW SELF ESTEEM	

MEDICAL HISTORY

MEDICAL CONDITIONS	TREATMENT DATE	NOT APPLICABLE	DETAILS
Epilepsy			
Migraine			
Anxiety			
Depression			
Mental health condition e.g., depression, stress/anxieties, bi-polar			
Dizziness			
Fainting			
Psychiatric treatment			
Headaches			
Any Medication you are currently taking			
Any other conditions you are being treated for?			

Note: If the reason for today's visit has to do with a medical or mental health issue, it may be necessary to obtain your doctors approval.

Is there any history of mental illness within your family e.g.: depression, suicide, anxiety?

Have you recently had or are having suicidal thoughts? Yes No
If yes please describe

Have you ever Life Coaching before? Yes No

What is your favourite season?

List any fears or phobias that you have

What kind of weather do you like the best?

Please list at least three benefits that you would gain by making the change/s that you desire

List three of your pastimes or hobbies:

Complete this sentence: I am happiest when

What do you want the outcome to be from this therapy?

If I could click my fingers and you were instantly better, or even cured, then HOW WOULD YOU KNOW?

All personal information will only be viewed by myself and the client named on this form.

CONFIDENTIALITY

Matters discussed between us will remain confidential. The exceptions to this confidentiality clause are if:

- I believe you or someone else is at risk of serious harm
- I hear of harm or abuse to a child
- I am ordered by a court of law
- I become aware of an act of terrorism

If I believe you are at risk of harming yourself, I will consider contacting your GP or Local Crisis Team. I would make every effort to discuss any concerns I have with you first.

DATA PROTECTION ACT

Storage of this information will be kept safe in a lockable storage cabinet and will be kept for 1 year for the purpose of the therapy sought and any possible future sessions required. Any personal details I keep are stored securely. Under the terms of the 1998 Data Protection. You must give your consent to such information being made and retained. By signing this agreement, you are giving such permission.

MISSED APPOINTMENTS AND LATE ARRIVALS

The duration of coaching sessions may vary, usually once a week. Should you arrive late for a session I will not be able to extend the session beyond our original scheduled ending time as I may well have another client due.

If you need to cancel a session, 24 hours' notice is required. One other session date will be offered as an option. On the rare occasion that I am unable to keep our appointment, I will give you as much notice as I can and I will rearrange as soon as possible.

FEES

fees will be confirmed at consultation and are dependent on treatment required. All fees are payable on confirmation of appointment time and are non-refundable.

DECLARATION

I understand that I am fully responsible for giving full details regarding my health.

I confirm that the above information is complete and accurate.

I will notify the hypnotherapist of any changes to my health or medication immediately.

I understand that my consultation and any subsequent therapy shall remain confidential except in situations where legal statute requires appropriate authorities to be notified. I agree that because people are individual and unique, there can be no guarantees regarding the outcome of any treatment, and I therefore agree that The Health Evolution accepts no liability in this regard.

I confirm and I fully understand that in order to obtain the best results, I need to work in a collaborative way with my coach and I understand that my full co-operation and positive input is required to obtain best results.

I hereby consent to this consultation and any subsequent treatment.

Date:
Client Signature: