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| **Initial Consultation Form**  **Unlock your potential, ignite your spark** | | | |
| **Contact Details** | | | |
| **Full name** |  | | |
| **Date of Birth** |  | **Age:** |  |
| **Gender**  **(current & past)** |  | **Marital Status:** |  |
| **Address** |  | **Who lives with you?** |  |
| **Phone (landline)** |  | | |
| **Phone (Mobile )** |  | | |
| **Email** |  | | |
| **Can messages be left on any of the contact numbers Yes/No**  **\*Please identify your preferred method of communication** | | | |
| **Employment status & Occupation** |  | | |
| **Medical History** | | | |
| **GP Name / Surgery** |  | | |
| **GP Contact number** |  | | |
| **Current health**  Are you struggling with anything that you have not been diagnosed with or discussed with a medical professional? |  | | |
| **Medication(s)**  **Including dosages** |  | | |
| **Are you receiving treatment elsewhere?** |  | | |
| **Medical History** | Pregnancy, Heart Conditions / High Blood Pressure, surgery interventions, Epilepsy, Diagnosed OCD, Psychosis, Diagnosed mental health conditions, epilepsy, seizures, panic attacks, asthma, pain, physical illness, allergies/anaphylaxis, trauma | | |
| **Do you experience depression or anxiety symptoms?** |  | | |
| **Do you smoke?**  (How many per day?) |  | | |
| **Do you drink alcohol?** (units per week?) |  | | |
| **How much caffeine do you drink per day?** |  | | |
| **How much water do you drink per day?** |  | | |
| **How much exercise do you get each week?** |  | | |
| **Do you take recreational drugs?** |  | | |
| **Do you have any sleep problems?** |  | | |
| **How would you describe your diet?** |  | | |
| **Family Medical History** |  | | |
| **Have you ever attempted suicide or harmed yourself in any way in the past?** |  | | |
| **Are you currently thinking about suicide or harming yourself in any way?** |  | | |
| **Describe your relationships** |  | | |
| **Describe your childhood** |  | | |
| **Work situation and dynamics** |  | | |
| **Financial issues** |  | | |
| **What do you do for enjoyment?**  Hobbies / interests |  | | |
| **Fears, phobias and dislikes** |  | | |
| **Describe your favourite place** |  | | |
| **Favourite colour** |  | | |
| **Describe your happiest memory** |  | | |
| **Therapeutic Goals** | | | |
| **What brings you to Sparks Therapies now?** |  | | |
| **What problems does it cause in your daily life?** |  | | |
| **Are there any known triggers for this particular issue?** |  | | |
| **Do you have any prior experience of therapy, counselling or any other therapies?**  If so, please list and state what, if any, impact they had on you? |  | | |
| **What is your understanding of hypnotherapy?** |  | | |
| **Therapeutic goal (What do you want to achieve?) in our sessions together?** |  | | |
| **Describe how you want your life to be after support from Sparks Therapies** |  | | |
| **Is there anything else you would like to share?** |  | | |