

confidential client information sheet

Name: _____

Address: _____

Postcode: _____ Email address: _____

Date of Birth: _____ Phone number: _____

Next of kin name and phone number: _____

Doctor's Name and Address: _____

Do you give me permission to contact your doctor if necessary?

Yes No

Are you currently under the care of a medical professional?

Yes No

Do you agree to attend sessions free from the affects of drugs and alcohol?

Yes No

Have you been diagnosed with epilepsy?

Yes No

Have you ever had any diagnosis from a psychiatric or mental health professional?

Yes No

Are you, or could you be pregnant?

Yes No

Please give details of any history of past or present mental health issues:

Details medications you have been prescribed by a medical health professional:

Please give any other details, which you feel may be relevant: _____

I confirm that the above details are correct
and complete to the best of my knowledge.

Signed: _____

representational system preference test

For each of the following statements, please add a number from 1 – 4, to indicate which statement is the MOST like you (4), the second most like you (3), through to the LEAST like you (1).

Every statement must have a number beside it. Do not use the same number twice in the same section. When you aren't sure, take your best guess or ask someone that knows you well.

Each question should use all of the numbers (1 – 4) once

1. I make important decisions based on:
 - gut level feelings
 - which way sounds best
 - what looks best to me
 - precise review and study of the issues

2. During an argument, I am most likely to be influenced by:
 - the other person's tone of voice
 - whether or not I can see the other person's argument
 - the logic of the other person's argument
 - how I feel about that person's argument

3. I mostly communicate what is going on with me by:
 - the look I give
 - the feelings I share
 - the words I choose
 - the tone of my voice.

4. It is easier for me to:
 - find the ideal volume and tuning on a stereo system
 - select the most intellectually relevant point of an interesting subject
 - select the most comfortable furniture
 - select attractive colour combinations

5. I am:
 - very sensitive to the sounds of my surroundings
 - very adept at making sense of facts and data
 - very sensitive to the way clothing feels on my body
 - very likely to have a strong reaction to colours and the way a room looks

outcome measures

Please fill in the below to the best of your ability. Over the last two weeks, I have ...

	Not at all	Several days	More than 1/2 the days	Nearly every day
1.1 Had days feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2 Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3 Been worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4 Had trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5 Been so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.6 Become easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.7 Felt afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.1 Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2 Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.3 Trouble falling/staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.4 Been feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.5 Had a poor appetite or been overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.6 Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.7 Trouble concentrating on things, such as reading the newspaper or watching the television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.8 Moving or speaking so slowly that people may have noticed - or the opposite, being so fidgety/restless that you've been moving a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.9 Thoughts that you would be better off dead or hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.1 Been feeling optimistic about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.2 Been feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.3 Been feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.4 Been dealing with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.5 Been thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.6 Been feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.7 Been able to make up my own mind about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>