cherie james
THERAPIST & WELLNESS COACH

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07824 037 348

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: _____

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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	☐	☐	☐	☐
1.2	Not being able to stop or control worrying	☐	☐	☐	☐
1.3	Been worrying too much about different things	☐	☐	☐	☐
1.4	Had trouble relaxing	☐	☐	☐	☐
1.5	Been so restless that it is hard to sit still	☐	☐	☐	☐
1.6	Become easily annoyed or irritable	☐	☐	☐	☐
1.7	Felt afraid as if something awful might happen	☐	☐	☐	☐
2.1	Little interest or pleasure in doing things	☐	☐	☐	☐
2.2	Feeling down, depressed, or hopeless	☐	☐	☐	☐
2.3	Trouble falling/staying asleep, or sleeping too much	☐	☐	☐	☐
2.4	Been feeling tired or having little energy	☐	☐	☐	☐
2.5	Had a poor appetite or been overeating	☐	☐	☐	☐
2.6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
2.7	Trouble concentrating on things, such as reading the newspaper or watching the television	☐	☐	☐	☐
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	☐	☐	☐	☐
2.9	Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐
3.1	Been feeling optimistic about the future	☐	☐	☐	☐
3.2	Been feeling useful	☐	☐	☐	☐
3.3	Been feeling relaxed	☐	☐	☐	☐
3.4	Been dealing with problems well	☐	☐	☐	☐
3.5	Been thinking clearly	☐	☐	☐	☐
3.6	Been feeling close to other people	☐	☐	☐	☐
3.7	Been able to make up my own mind about things	☐	☐	☐	☐

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somatic EMDR intake form

Please fill in the below to prepare for our somatic EMDR work.

Have you had surgery recently (within the last year, particularly eye surgery for EMDR)?

Is your appetite good? How would you characterise it?

How many hours on average do you sleep per night? _____

Do you participate in any regular physical activities? Please describe below.

What would you really like to change about your life?

Short Term: _____

Mid Term: _____

Long Term: _____

PRE-DISCOVERY SESSION AREA'S TO THINK ABOUT

We will go through the following in your discovery session. However you can start to think about which of the following 2 areas you would like to work on with me.
Circle 2 of the categories and think about the answers before we meet.

1) PAST – Is there something in your past you'd rather forget, let go of or the memory of it causes you distress right now? Think about any dominant characteristics of these memories (images, smells, sounds, recurring dreams, etc.) that continue to surface (if any).

2) PRESENT – Is there anything happening in your life currently causing you distress? Think about how it feels in your body when you think of these now?

3) FUTURE – Are there any upcoming events causing you to experience excessive fear or anxiety (deadlines, social events, competitions, work related issues)?

4) CONTROL – Is there anything you'd like to take more control over right now? If you could wave a magic wand and suddenly have complete control over something what would that look like in your life?

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What experiences or positive feelings come to mind when you consider any of the following (feel free answering only 2 of the areas below):

1) HAPPY MEMORY – Is there a happy memory that comes up that makes you smile? Please describe.

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2) APPRECIATION – Are there any examples you can recall when you were appreciated for an accomplishment or action? Alternatively, are there any examples where you were appreciative or grateful for something that was **given** to you (i.e. you experienced an act of kindness, given a gift, good health, politeness, smiles, sunrises, being at the beach, a supportive friend/partner of family member helped you, etc.)?

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3) POSITIVE EXPERIENCE – Is there a positive experience you'd like to recall that makes you feel good about yourself or about someone else (i.e., sharing a laugh, playing a game with others, winning a competition…)?

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4) SKILLS AND STRENGTHS – What abilities, attributes, capabilities or talents do you have that you recognise are helpful to you and others (i.e., you're a good parent, you're a good friend, you're good at math, you're a good listener, you have a nice smile, you play an instrument, you enjoy reading, you're good with your hands, etc.)

Ask yourself the following — giving yourself marks out of 10, with 0=low and 10=high.

How willing are you to be honest about your flaws and difficulties?

0 1 2 3 4 5 6 7 8 9 10

How self-disciplined are you when you set your heart on something?

0 1 2 3 4 5 6 7 8 9 10

How prepared are you to do some extra work in between sessions?

0 1 2 3 4 5 6 7 8 9 10

How much do you like problem solving?

0 1 2 3 4 5 6 7 8 9 10

How willing are you to do things to change even though it feels strange and unfamiliar?

0 1 2 3 4 5 6 7 8 9 10

How difficult do you find it to tune into your feelings?

0 1 2 3 4 5 6 7 8 9 10