**The Mind Bridge Therapy Ltd.**

**New Client Contact Form and Health Questionnaire**

Full details of how your data is collected, stored and deleted is available in **Therapy Privacy Policy**. A current copy of the **Therapy Privacy Policy** is downloadable from my website at <https://www.themindbridge.co.uk/policies>

|  |  |  |  |
| --- | --- | --- | --- |
| **ABOUT YOU** | | | |
| **NAME** |  | **ADDRESS** |  |
| **DATE OF BIRTH** |  |
| **AGE** |  | **POSTCODE** |  |
| **PREFERRED CONTACT DETAILS** | | | |
| **PHONE** |  | **EMAIL** |  |
| **GP DETAILS –** I would only contact your GP with your consent, or if I was concerned with your immediate wellbeing or others. | | | |
| **GP PRACTICE ADDRESS** |  | **GP NAME** |  |
| **EMERGENCY CONTACT NAME AND TELEPHONE NUMBER** – to be used if you are taken ill during a session and are unable to notify a friend or relative. | | | |
| **NAME** |  | **PHONE** |  |
| **MEDICATION AND HISTORY** | | | |
| **MEDICATION** |  | **ANY PREVIOUS PSYCHOLOGICAL TREATMENT OR THERAPY** |  |

***How to complete the questionnaire below:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Condition | No/Yes (please provide details) |  | Condition | No/Yes (please provide details) |
| *Diabetes* | ***Yes – Type II*** |  | *Epilepsy* | ***No*** |

***Health Questionnaire – current and previous history***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Condition | No/Yes (please provide details) |  | Condition | No/Yes (please provide details) |
| *Diabetes* |  |  | *Epilepsy / fainting / narcolepsy* |  |
| *Depression (clinical)* |  |  | *Bi-polar disorder* |  |
| *Pregnancy* |  |  | *Dementia* |  |
| *Pain disorders* |  |  | *Addiction(s)* |  |
| *Anxiety (Generalised / Phobias)* |  |  | *History of Trauma and/or PTSD* |  |
| *Self-Harm or suicidal thinking (current or previous)* |  |  | *Disordered eating / Anorexia / Bulimia / EDNOS / OSFED* |  |
| *Schizophrenia / Psychosis (current or previous) or immediate relatives with psychosis (parents or siblings)* |  |  | *IBS / Chronic Fatigue Syndrome /*[*Bruxism*](https://therapypartnership.com/bruxism.htm)*(teeth grinding) / Fibromyalgia* |  |
| *Personality disorders (Dissociate Identity Disorder)* |  |  | *Serious heart conditions, High or low blood pressure* |  |
| **Any other comments or information** | ***Other*** | | | |

**Why have I asked these questions?**

It is helpful and important that I understand any health concerns or underlying issues, whether physical or mental. This allows me to help work with you in a way that best suits your needs.

As I mentioned above, your health, comfort and safety are of paramount importance for me, therefore below I attach a list of potential contraindications for use of hypnosis in therapy.

Certain health conditions may be incompatible with hypnotherapy, or require me to take additional steps for your wellbeing during our sessions:

***Hypnotherapy******is not recommended if you have any of the following conditions:***

* Schizophrenia
* Pathological personalities / dissociative identity disorder
* Chronic alcohol or drug abuse
* Epilepsy and narcolepsy are conditions usually regarded as contraindicated, unless exceptional circumstances in which you have both GP and the doctor's approval
* Bi-polar conditions
* Suicidal tendencies
* Clinical depressive illnesses
* Senility
* Serious heart conditions may also be contraindicated
* Extremely high or low blood pressure

***Hypnotherapy may be suitable, with adjustments:***

* Pregnancy (for example, focussing on relaxation and confidence building)

## **Please sign and date below to confirm that you have understood the questions and answered them honestly. A digital signature (or your handwritten name and signature) is acceptable.**

**I have read, understood and declare that the information provided above is accurate, honest and complete to the best of my knowledge.**

**Print Name: Signature:**

**Date:** / /