Health Assessment Questionnaire Private and Confidential

Please tick the appropriate boxes, providing further details where necessary

Are you currently experiencing any of the following conditions? YES NO

Heart problems? ☐ ☐

Migraine or epilepsy? ☐ ☐

Physical pain or injury? ☐ ☐

Any specific fears or phobias? ☐ ☐

Please answer the following questions, adding further details where appropriate. Have you ever been diagnosed as suffering from any psychological or psychiatric condition?

If appropriate, have you consulted your GP about the condition(s) for which you are seeking therapy?

Do you have other health condition(s) which you think may be relevant?

Are you currently using any prescription medications?

Do suffer from IBS or any other gastro-intestinal issues?

Do you suffer or have difficulty with tension in any particular part of the body?

Number of cigarettes smoked per day: Alcohol consumption per week: Caffeine consumed per day:

Do you, or have you ever, used any illegal drugs?

Briefly describe your sleep: (Trouble falling asleep? Waking during the night? Waking early?

Briefly describe your level of exercise per week:

Declaration The information given above and throughout this consultation is, to the best of my knowledge, full and correct.

Signature: Date