# Client Intake Form

**[Your Practice Name]**

Please complete this form before your first session. All information is confidential.

## Personal Information

| **Full Name** |  |
| --- | --- |
| **Preferred Name** |  |
| **Date of Birth** |  |
| **Email** |  |
| **Phone** |  |
| **Address** |  |
| **Emergency Contact** | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## What Brings You Here?

| **What are you hoping to achieve through our work together?** |
| --- |
|  |
| **Have you worked with a [therapist/coach/etc.] before?** |
| ☐ Yes ☐ No If yes, when and what was your experience? |
|  |

## Medical & Health Information

*(Customize this section based on your practice area)*

| **Are you currently under the care of a GP or other healthcare provider?** |
| --- |
| ☐ Yes ☐ No Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Any current medications or supplements?** |
|  |
| **Is there anything else about your health I should know?** |
|  |

## Consent & Agreement

☐ I confirm that the information provided is accurate to the best of my knowledge

☐ I have read and agree to the Privacy Policy

☐ I understand the fees and cancellation policy

☐ I consent to my information being stored securely in accordance with GDPR

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_