|  |  |
| --- | --- |
|  | Natural Magick |

## CLIENT PERSONAL INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | DOB: |  |
|  | Last | First | title |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | House/ Flat and street name  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | County | Postcode |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

## EMERGENCY AND MEDICAL

|  |  |  |  |
| --- | --- | --- | --- |
| Person to contact in an emergency |  | TEL: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Doctors Name: |  | Surgery Address: |  |

|  |  |
| --- | --- |
| Current medication –  |  |

|  |  |  |
| --- | --- | --- |
| Have you received this therapy before?  | YES[ ]  | NO[ ]  |

## UNDERSTANDING YOUR LIFESTYLE

What difficulties/problems do you find yourself having to deal with currently?

How would you describe the emotions attached to any of the problems you’ve described? How do they manifest? What triggers them?

|  |  |
| --- | --- |
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|  |  |
|  |  |
| How would you describe your current lifestyle/circumstances? |  |
|  |  |
|  |  |
|  |  |
| How has your general wellbeing been in the last week  | 1 as bad as it could be…. 2… 3… 4 …5… 6… 7… 8… 9… 10 as good as it could be |
| Comments  |  |

## ASPIRATIONS AND INTENTIONS FOR THERAPY

|  |
| --- |
| Please write a short goal for what you would like flower essences to do for you (how would you like to feel in say 4 weeks time) |
|  |

|  |
| --- |
| Goal: |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
| Please write a long-term goal for what you would like flower essences to do for you? (say in 6 months or more Remember the emphasis is on how you would like to feel) |
|  |

|  |
| --- |
| Goal: |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| What is your main reason for wanting to try essences? |
|  |

|  |
| --- |
| Reason: |

##  *(to be completed by therapist)*  BLEND AND DOSAGE

|  |  |  |  |
| --- | --- | --- | --- |
| Essences  |  |  |  |
|  |  |  |  |
| Dosage: |  |

## Disclaimer and Signature

This is a Holistic Complementary Therapy and the treatments given are not taking the place of Conventional medicine. You will be advised to seek medical attention when needed. Every effort is made to encourage patients to give full details of any other treatment they have received or are receiving from whatever direction.

By signing this form, you agree that you have read the foregoing notes and confirm that they are a true record. You have not withheld any information which might affect the course of your treatment and you undertake to keep your therapist Informed of any changes in your health and in any prescribed of self-administered medication in order to facilitate an update of this record, when necessary.

The information you have given is strictly Private and Confidential.

Client Name/Guardian (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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