**Liz Hart New Client Information Form**

**This questionnaire will take about 1 hour to complete fully**

**and is an essential component of your treatment plan.**

Please email this completed form to lizhart@slingshot.co.nz **at least 48 hour prior to your appointment.** This will allow time for it to be reviewed before I see you. Delayed or incomplete forms may mean we have to spend consultation time completing the form together and delay the onset of our work towards gaining you some relief and resolution.

Total wellbeing comes from a range of activities, circumstances and internal states, and this questionnaire is to help me get to know what’s happening in your life so I can assist you to find more success, happiness and peace in your endeavours. The questions are far ranging as your mental, emotional physical and spiritual wellbeing are all linked, and a problem in one can affect your wellbeing in other aspects of your life too. Please answer each question as fully as you can.

**If you find any questions distress you, make a note beside the question and continue to the next question; we can address it in person when we meet.**

**Thank you and I look forward to meeting you soon.**

Name: Male/female DOB:

Address:

Email:

Mobile: Skype:

Emergency contact person: PH:

Single / partnered / married / separated / divorced / widowed How long in current status?

Partner / ex’s first name\*:

Children – first names & ages

Mother alive / deceased name I call her (mum, mother etc)

Father alive / deceased name I call him (dad, father etc)

Siblings – first names and ages

\*Names allow you to make a closer emotional identification with the person during our work.

Employment status: student / home worker / part time / full time / voluntary / retired / other?

Job description

**Please list the top 3 problems facing you now:**

Problem 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did this problem begin (your best guess)?
2. Circle the number that represents how impactful the problem is for you:

(Very low impact/rarely) 1 2 3 4 5 6 7 8 9 10 (very high impact/daily)

1. Why do you think you have this problem?
2. Give some specific examples of how this happen in your life?
3. Complete this sentence: “I haven’t been able to get over this problem because…
4. Complete this sentence: “What I’ve learnt about my problem is…
5. Complete this sentence: “What I might need to resolve first to get over this problem is…
6. Complete this sentence: “What I’m most afraid of in exploring this problem is…
7. How is your life different since this problem showed up?
8. What other bigger problem might come up if you resolved this?
9. Who else may be affected positively or negatively if you resolve this and how?

**Problem 2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did this problem begin (your best guess)?
2. Circle the number that represents how impactful the problem is for you:

(Very low impact/rarely) 1 2 3 4 5 6 7 8 9 10 (very high impact/daily)

1. Why do you think you have this problem?
2. Give some specific examples of how this happen in your life?
3. Complete this sentence: “I haven’t been able to get over this problem because…
4. Complete this sentence: “What I’ve learnt about my problem is…
5. Complete this sentence: “What I might need to resolve first to get over this problem is…
6. Complete this sentence: “What I’m most afraid of in exploring this problem is…
7. How is your life different since this problem showed up?
8. What other bigger problem might come up if you resolved this?
9. Who else may be affected positively or negatively if you resolve this and how?

**Problem 3:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did this problem begin (your best guess)?
2. Circle the number that represents how impactful the problem is for you:

(Very low impact/rarely) 1 2 3 4 5 6 7 8 9 10 (very high impact/daily)

1. Why do you think you have this problem?
2. Give some specific examples of how this happen in your life?
3. Complete this sentence: “I haven’t been able to get over this problem because…
4. Complete this sentence: “What I’ve learnt about my problem is…
5. Complete this sentence: “What I might need to resolve first to get over this problem is…
6. Complete this sentence: “What I’m most afraid of in exploring this problem is…
7. How is your life different since this problem showed up?
8. What other bigger problem might come up if you resolved this?
9. Who else may be affected positively or negatively if you resolve this and how?

|  |  |
| --- | --- |
| **Type YES in the column next to each question if this was true for you****While you were growing up, during your first 18 years of life:**  | **TRUE FOR ME** |
| Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you, or act in a way that made you afraid that you might be physically hurt? Did this happen to a sibling(s)? |  |
| Did a parent or other adult in the household often push, grab, slap, or throw something at you or a sibling or ever hit you or your sibling so hard that it left marks or injuries? |  |
| Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or attempt or actually have oral, anal, or vaginal intercourse with you? |  |
| Did you often feel that no one in your family loved you or thought you were important or special or your family didn’t look out for each other, feel close to each other, or support each other? |  |
| Did you often feel that you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it? |  |
| Were your parents ever separated or divorced or never lived together? |  |
| Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her? Or sometimes kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit for at least a few minutes or threatened with a weapon or some kind? |  |
| Did you live with anyone who was a problem drinker or alcoholic or who used street drugs or abused prescription medications? |  |
| Was a household member depressed or mentally ill, or did a household member attempt suicide? |  |
| Did a household member go to prison? |  |
| Did you often experienced discrimination or bullying based on race, sex or sexual orientation, financial status, politics, religion, ability or disability, personal appearance, health status or your relationship with other people or did you very often witnessed this kind of discrimination? |  |
| Did you move house at least 5 times? |  |
| Did you move schools at least 5 times |  |

|  |  |
| --- | --- |
| **Type YES if this is true for you** | **TRUE FOR ME** |
| I am able to think about my problems and figure out what to do to make it better |  |
| I am good at calming myself down so I can think before acting |  |
| I feel good about myself for the positive things I can do  |  |
| I have talents I and society value |  |
| I believe I can influence what happens in life by what I decide and do |  |
| I have religious / spiritual beliefs that support me and help me make decisions |  |
| I have a positive attitude about life even when faced with difficulties |  |
| I have a likeable personality that people like to be around |  |
| I believe I am a strong person because of the difficulties I have faced |  |
| I am personally motivated to make positive changes in my life |  |

|  |  |
| --- | --- |
| I have a positive family member who gives me support in good times and bad |  |
| I live in a safe home where people get along well |  |
| I have a family member who believes in me and expects me to do well in life |  |
| I have someone I can trust to share my feelings with openly and honestly |  |
| The people I live with are mentally well |  |

|  |  |
| --- | --- |
| I have at least one positive friend outside my home who give me support |  |
| I have positive activities I like to do with others |  |
| I feel safe in my community and the places I usually go |  |
| I feel connected with the people in my community |  |
| I have a positive relationship with my employer and co-workers |  |

|  |  |
| --- | --- |
| I maintain a positive balance between work, family, social and other commitments and time for myself |  |
| I take time to look after my health and exercise needs |  |
| I eat healthy food in appropriate amounts |  |

**Have you ever received a mental health diagnosis from a certified medical practitioner?**

1. Who? PH: Email:
2. What?
3. When?
4. Past treatment:
5. Current treatment:
6. Medications:
7. Other complementary or self-help treatments:
8. May I contact them for further information if required:

**Have you consulted with any health practitioner in the last two years?**

1. Reason for consultation?
2. Who did you consult with? PH: Email:
3. Tests and results?
4. Diagnosis?
5. Current treatment?
6. Medications?
7. Other complementary or self-help treatments?
8. May I contact them for further information if required?

**Anything else you think might help me to know and understand you better?**

**Looking forward:**

What are your goals for yourself in consulting with me?

How possible do you believe it is for you to achieve those goals?

Not at all 0 . . . . 50/50 . . . . 10 Absolutely

How much effort do you believe it will take from YOU to achieve these goals?

Few minutes a day 1 . . . . 5 regular focus . . . . 10 Really hard work

How willing are you to make the effort required to achieve your goals?

I’m struggling as it is 1 . . . 5 I’ll fit it in somehow . . . . 10 It’s my top priority

How will your life be different (in positive terms) when you achieve your goals?

Thank you for taking the time to complete this form. I hope it has been an interesting and enlightening process for you. Your information will be held securely and will be used to develop a program for you to achieve your goals during our first consultation.

Please save this document as “your name GHC intake form” and email to me now at lizhart@slingshot.co.nz