VERITY BRIGHTSIDE-JOHNS

CONFIDENTIAL CLIENT QUESTIONNAIRE

Your work with me is entirely individual. This questionnaire allows me to understand your history, circumstances and what you would like to address before we meet, so that our time together can be focused entirely on your recovery.

Personal Details

Name:

Preferred name:

Address:

Occupation:

Contact number:

Date of birth:

Email:

GP's information:

Emergency contact nar

Emergency contact number:

Relationship to you:

What You Would Like to Change?

If you could remove any limitations and address any of your issues, what would be the most important items for you to work on in your sessions with me?

Significant Life Experiences

Please tell me about any significant or difficult experiences in your life that you feel could be relevant, with approximate dates / age where possible.

Relationships

If you are able, please describe the relationship challenges you wish to address, including past and present issues with friends, family, work etc.

Family Situation

Single | Living alone | Living with parents | Living with partner | Married | Separated | Divorced | Widowed | Other

Current Professional Support

Are you currently receiving support from any other healthcare or therapeutic professionals?

Yes No

If yes, please provide brief details:

Previous Therapy & Treatments

Have you previously received any therapy, counselling, complementary or alternative treatments relating to the issues you would like to address?

Yes No

If yes, please briefly describe what you tried and whether you found it helpful:

Medical History

Please list any past surgery, serious illnesses, accidents or injuries, with approximate dates/ages where possible:

Do you have a pacemaker?

Yes No

Have you ever had a mammogram?

Yes No N/A

Have you ever sprained your ankle?

Yes No Right Left Both

Have you ever had root canal surgery?

Yes No

Significant childhood illnesses: Chicken Pox Glandular Fever Other:

Are you currently pregnant?

Yes No N/A

If yes, how many weeks pregnant are you?

Medications

Please list any current medication and what it is for:

Have you ever had a reaction to any medication?

Yes No

If yes, please give details of the medication, reaction and approximate date/age:

Lifestyle

Do you smoke?	Yes	No
Do you drink alcohol?	Yes	No
Do you currently use recreational drugs?	Yes	No
Have you used recreational drugs in the past?	Yes	No

If yes, please give brief details:

Current & Previous Symptoms

For each symptom, please indicate whether you currently experience it or have experienced it in the past. For current symptoms, please indicate whether they are Mild, Moderate or Severe.

	Cur	Past	Mild	Mod	Sev
Acne					
Anxiety					
Back pain					
Brain fog / difficulty concentrating					
Breathing difficulties					
Chest pains					
Constipation					
Depression					
Digestive problems / bloating					
Dizziness					
Eczema					
Fainting / fits					
Fatigue / exhaustion					
Headaches					
Hearing problems					
Hormonal problems					
Joint pain					
Known allergic reactions					
Lethargy					
Loose bowels					
Low mood					
Low self-esteem / confidence					
Low sex drive					

	Cur	Past	Mild	Mod	Sev
Menopausal problems					
Migraines					
Mood changes / irritability					
Neck / shoulder pain					
Nervous twitches / tremors					
Obsessive or intrusive thoughts					
Other sexual problems					
Palpitations					
Panic attacks					
PMT / Menstrual problems					
Poor circulation					
Poor sleep					
Repeated infections					
Runny nose					
Sore throat					
Stress / overwhelm					
Stuffy sinuses					
Tinnitus					
Unexplained weight changes					
Vision problems					
Watery eyes					

Other problems

Please provide any additional information you feel may be relevant:

Client Declaration

I understand that Verity Brightside-Johns does not diagnose medical conditions or provide medical treatment. Her work is complementary, can work in conjunction with other medical or therapeutic care, and is not a substitute for appropriate medical or psychological treatment.

I understand that I remain responsible for seeking advice from my GP or other qualified healthcare professionals regarding any medical or mental health concerns.

I understand that any information, guidance or recommendations provided are for me to consider, and that I remain responsible for my own choices, decisions and actions.

I confirm that I have read, understood and agree to the Terms of Service and Privacy Policy provided to me before my appointment.

Signed:

Date:

Privacy & Data Protection Consent

I consent to Verity Brightside-Johns securely collecting and storing the personal information necessary to manage my appointments, maintain appropriate client records and communicate with me regarding my care.

Information held may include: Name, Address, Telephone number, Email address and Appointment details.

Client case notes are stored securely and separately from contact and booking information and are accessible only by Verity Brightside-Johns.

Client case notes will be retained securely for seven years following your last appointment, in accordance with professional insurance requirements, after which they will be securely destroyed.

Signed:

Print Name:

Date: