

Client Registration with Sherree Russell BSc Clinical Hypnosis

Strictly Confidential

Name

Address

Phone number

Email

Date of Birth

Age

Status

Children – names & ages :

Occupation

Do you take any exercise? YES/NO (if yes please give details).

This medical information is highly unlikely to ever be needed but legally I have to ask

GP Name & Surgery Address

Do you have any current medical conditions?

Have you had treatments from a Psychiatrist, psychologist, therapist or counsellor?

If yes, when and what for?

Any other medical information that you may deem appropriate

Are you taking any Medication or Drugs? YES/NO (if yes please give details)

Details of person to contact in case of emergency & their telephone number:

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Briefly - What is the reason for your consultation?

How long have you had this problem/issue?

Can you pin point the cause?

On a scale of 0-10 – how does this disrupt your enjoyment of your riding?

On a scale of 0-10 – how does this impact other areas of your life?

How does this problem affect you:

Physical symptoms

Emotional symptoms - Please complete the Tick chart below.

If you answer yes to a question please give it a score out of 1-5.

E.g. the symptom/s being at best –1 and at worst –5.

	Yes	No
Any insecurities		
Low self esteem		
Lack of confidence		
Disturbed sleep or insomnia		
Mood swings		
Depression		
Anxiety		
Lack of concentration		
Stress		
Tension headaches		

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Please tell me about your Horse:

Name

Breed

Height

Age

Sex

How long have you owned him/her?

Has this horse contributed to your current problem and how?

Is this horse still contributing to your current issue?

Is there another horse / horses that contributed to this problem?

What have you tried so far to try and make this feeling go away?

Who is your Instructor/Trainer?

How long have you been working with them?

Do you compete – if so what discipline & level?

What level are you working at home?

Do you have any other worries/problems/stress going on in your life right now?

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What are you hoping to achieve from receiving therapy?

How would you like to conduct your session? Please tick

Visit my practice in West Chilmington, RH20 2QY.

Home visit

Skype – number

Voice call

Face-Time

other ?

Details of person to contact in case of emergency -
(only needed if you are visiting my practice)

Your Signature

Print name

Date

How did you hear about me?