

# CONFIDENTIAL CLIENT HISTORY FORM

Date \_\_\_\_\_

Name \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Mob \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ No of children \_\_\_\_\_

How did you hear about me ? Internet \_\_\_\_\_ Referral \_\_\_\_\_ Other \_\_\_\_\_

Have you used EFT before ? \_\_\_\_\_ Reason \_\_\_\_\_

Any previous attempt to address this issue Yes \_\_\_ No \_\_\_ Results \_\_\_\_\_

Give a brief account of the history and development of your issue \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to achieve with our sessions together

\_\_\_\_\_  
\_\_\_\_\_

During the sessions we will constantly be checking the intensity of the presenting problem. Please rate the intensity of your issue now between 0 and 10, 10 being the strongest intensity and 0 no intensity at all

0 1 2 3 4 5 6 7 8 9 10

Do any of the following apply to you ?

Insomnia	allergy	panic attack	tiredness	boredom	loneliness
over-eating	under-eating	self-doubt	substance abuse	cant relax	obsessions
not good enough	failure	never enough	sexual issues	worrier	abandonment issues
anger/rage	depression	fear and phobias	poor self-image	inferiority feelings	withdrawn
asthma	nightmares	indifference	distrustful	over ambitious	indecisive
gambling	career issues	self hatred	fear of ageing	out of control	other

## Medical history

Have you or are you undergoing medical or psychological treatment for any of the above issues ?

Yes \_\_\_ No \_\_\_ If so, where \_\_\_\_\_ Name Dr. \_\_\_\_\_

Have you ever been treated for emotional problems ? Yes \_\_\_ No \_\_\_ If yes, are you currently receiving treatment or counselling ?

Yes \_\_\_ No \_\_\_

Have you ever been treated for Heart --- Diabetes \_\_\_ Epilepsy \_\_\_ and are You currently taking any medications ? Yes \_\_\_ No \_\_\_

Reason for medication and what medication \_\_\_\_\_

Have you had any prolonged illness ? Yes \_\_\_ No \_\_\_ If yes, what illness \_\_\_\_\_

How are your sleeping patterns ? \_\_\_\_\_

Are you experiencing any physical pains ? \_\_\_\_\_

I give Helene Ludwig permission to use/teach me EFT Emotional Freedom Technique

### Disclaimer

EFT is not a substitute for medical or psychological/mental health treatment. EFT is an energy therapy and you agree to assume full responsibility for any and all risks associated with using EFT.