aMINDSET ONLINE PSYCHOTHERAPY - CONFIDENTIAL DATA FORM

Full Name: _____

Address: _____

Phone: _____ **E:Mail:** _____

Sex: ☐ M ☐ F **D.O.B.** _____ **Occupation:** _____

Medical History: **Please briefly detail any psychological or physiological ailments and if you are currently registered with a psychiatrist or on prescriptive medication**

_____

_____

_____

_____

Do you smoke? ☐ Y ☐ N **Do you drink alcohol?** ☐ Y ☐ N

Reason for Consultation:

_____

_____

_____

_____

_____ _____

Signature of Patient **Date**

Note: Please sign by printing your name or adding a digital signature. By lodging this form with aMindset, you acknowledge that you have read and accepted the aMindset Disclaimer and Medical Disclaimer