FLOWER ESSENCE BACKGROUND INFORMATION FORM FOR ADULTS WITH SYMPTOMS OF ATTENTION DEFICIT DISORDER [AND HYPERACTIVITY]

Please note: This form is intended to document important data central to Flower Essence therapy. It is best if the client completes this form in his or her own handwriting. If this is not possible, the practitioner can use an interview format to gather the information.

Referred by _____

Full name _____ Date _____

Address _____

_____

Email _____

Telephone[s] -Home _____

Work _____

Date and place of birth _____ Present Age _____ Sex M/F _____

Marital status _____ Number of ___ and ages of children _____

Living alone or with others _____

Employment/profession _____

Other main activities/hobbies, interests _____

_____

Have you used Flower Essences before? How did you find out about them? Brief summary of your experience _____

_____

_____

Issues I would like to address with Flower Essences: Check all that may apply:

To deal with negative/painful emotions	_____	For greater spiritual awareness	_____
To help in relationships with others	_____	For shifts in physical healing	_____
Greater clarity about my lifework & direction	_____	To introduce a more positive attitude toward life	_____
Improve self-image & feelings about myself	_____	For an immediate crisis(describe below)	_____
Enhance creativity and self-expression	_____	For long-term inner growth & change	_____
Coping with stress & the demands of life	_____	Other _____	

Please comment on the above areas

_____

_____

_____

_____

Official diagnosis *[if any]* _____

Age *[first noticed]* _____

Check where appropriate: Presently and in the past I have experienced....

[ ] Feeling alien/not belonging	[ ] Loneliness	[ ] Rejection	[ ] Daydreaming
[ ] Apathy/disinterest	[ ] Depression	[ ] Sadness/grief	[ ] Anxiety
[ ] Fearful	[ ] Worry	[ ] Guilt	[ ] Self-hatred
[ ] Lack of confidence	[ ] Self-sabotage	[ ] Shyness	[ ] Insecurity
[ ] Stress	[ ] Impatience	[ ] Anger	[ ] Irritability
[ ] Temper tantrums	[ ] Resentment	[ ] Inflexibility/rigidity	[ ] Difficulties learning
[ ] Mood swings	[ ] Impulsiveness	[ ] Upset by spontaneity	[ ] Overwhelm
[ ] Obsessions	[ ] Need for perfection	[ ] Forgetfulness	[ ] Disorganization
[ ] Distraction	[ ] Focusing difficulties	[ ] Hyperactivity	[ ] Restlessness
[ ] Low self-esteem	[ ] Feeling clumsy, poor body image		

[ ] Other [described] _____

_____

_____

In the past have you used drugs/alcohol for relief, and if so, to what extent

_____
_____
_____

Brief description of your general state of health:
Physical *[Note any significant medical history, diet, exercise, energy level, etc.]*
_____
_____
_____
_____

Emotional-*[feelings about self or others, on-going issues or areas of conflict]* _____
_____
_____
_____

Mental-*[outlook on life, beliefs and attitudes]*
_____
_____
_____
_____

Spiritual-*[ultimate sense of purpose, moral or religious values]* _____
_____
_____
_____

How do you feel about your work and other vocational interests? _____
_____
_____
_____

How do you feel about your relationships, especially major relationships? _____
_____
_____
_____

Briefly discuss your family background: [Origins, traumas, losses, divorces, or addictive behaviors]
_____
_____
_____
_____

Traumas: In your past, are you aware of anything traumatic that may have occurred to you or those close to you?
_____
_____
_____

a] In utero [Pre-birth] *[parental discord, separation, loss]*
_____

_____
_____

b] Birthing process. [ ] Natural childbirth [ ] Forceps-assisted [ ] Breech-birth [ ] Caesarian
(for Male) [ ] Circumcision?

_____
_____
_____

[ ] Nursed, and if so, for how long? _____
[ ] Adoption/Foster care? If yes, describe what you know, and at what age.

_____
_____
_____
_____

[ ] First 3 years, were you in childcare? Describe what you know _____
_____
_____

Birth Mother's Physical/Emotional availability early years? [ ] Good [ ] Average [ ] Poor
_____
_____

Birth Father's Physical/Emotional availability in early years? [ ] Good [ ] Average [ ] Poor
_____
_____

Bedwetting -as a child? _____
_____
_____

After childhood inoculations, any
reactions_____
_____
_____

Allergies, sensitivities in the past, or now
_____
_____
_____

Chronic skin problems in the past or now _____
_____
_____

Sleeping problems in the past or now? _____
_____
_____

Accidents, deaths/losses of family members

_____
_____
_____
_____

Any other therapies or significant growth experiences you are presently undergoing?
Are you taking any medication, or are you on any special dietary program?

_____
_____
_____
_____

If there is any other information you think would be helpful attach additional sheets as needed.

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