

**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....

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

522 CARMEL CIRCLE, SAN MATEO, CA 94402-2015.

TEL: (650) 348-7697 FAX: (650) 348-8947 E-mail: essences@patsgarden.com