COMPANY WELLNESS Solutions

Making Your Workplace Better

INTAKE FORM

NAME:

SURNAME:

ID NO.: GENDER:

COMPANY: EMPLOYEE NO.:

CELL NO.: ALT CELL NO.:

HOME ADDRESS: _____

_____

What problem are you seeking help with?

_____

_____

_____

Company Wellness Solutions (PTY) Ltd
Tel: 011 706 9945, Web: www.companywellness.co.za
First Floor, Block Six, Fourways Office park, 40 Roos Road Fourways.

COMPANY WELLNESS Solutions

Making Your Workplace Better

Do you have any history of medical illness?

Yes ☐ No ☐

If yes, please state

_____

Do you have any history of mental illness?

Yes ☐ No ☐

If yes, please state

_____

Are you currently on any medication?

Yes ☐ No ☐

If yes, please state type

_____

In case of emergency who can we contact:

Name:_____

Phone number:_____

Relationship:_____

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PLEASE TICK THE BOX(s) THAT APPLY TO YOU

- ☐ Headache
- ☐ Dizziness
- ☐ Have no appetite
- ☐ Eating too much
- ☐ Drinking alcohol to cope
- ☐ Using drugs most of the time
- ☐ Losing weight
- ☐ Gaining weight
- ☐ Feeling sad
- ☐ Body Ache
- ☐ Crying spells
- ☐ Excessive Guilt
- ☐ Racing thoughts
- ☐ Not enjoying activities once enjoyed
- ☐ Walking, talking or writing slower than usual
- ☐ Forgetting easily
- ☐ Getting irritated quickly
- ☐ Cannot sleep
- ☐ Sleeps too little
- ☐ Feeling tired most of the time
- ☐ Sleeps too much
- ☐ Thinking about commiting suicide
- ☐ Mood swings
- ☐ Excessive energy
- ☐ Anxiety attacks
- ☐ Avoidance

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