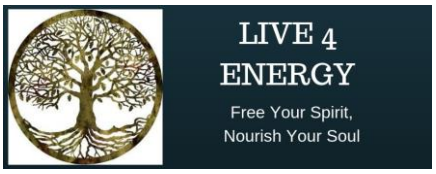
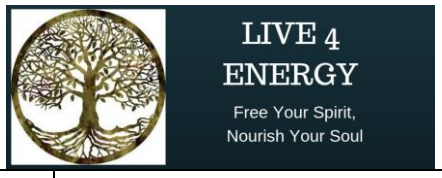


NAME: ADDRESS:

Email: Telephone Number:

How many family members wish to participate?	
What ages are they?	
What is the problem you wish to work on?	
Are there any other problems you are aware of?	
How does this problem Effect you?	
When did you first become Aware of this Problem?	
Do you have any physical aches, pains, problems? Please note where and what…	
What was happening in your life when this first started happening?	



What do you want to achieve from this therapy? Be Specific	
What are you goals from this therapy? What will be different that you feel, see, hear etc?	
Is this within your control to do? Or does someone elses need to do something to achieve this ?	

This form has been completed because I wish to receive Free Mental Health Alternative Therapy sessions as part of this Research Programme for my family.

I/We agree to complete 6 weeks of the 18 month programme and complete the paperwork as required for the research material to be compiled.

I/we agree to media images/footage to be taken and used as part of the evidence for the Research Programme and to promote further programmes being undertaken in the future.

I understand that we can withdraw at any point from the Research programme without incurring any cost or repercussions on our behalf financially and that we take full liability for mine and my families mental health during this process and do not hold anyone else liable for our state of mind and health.

Name: …… Date ……

Signature …… Date ……..