Micro Miracle FOUNDATION

Out of difficulties grow miracles

Beneficiary Application

Personal Details Parents/Centre:

Name & Surname:		
Physical Address:		
E-mail:		
Telephone nr: Cell:	Home:	Work:
Date of Birth:		
Gender: Male ☐ Female ☐		

Personal Details of Beneficiary:

Name & Surname:		
Physical Address:		
Telephone nr: Cell:	Home:	Work:
Date of Birth:		
Gender: Male ☐ Female ☐		
Medical Practitioner:		
Medications:		
Allergies:		
Emergency Contact : (Name and number)		

Micro Miracle FOUNDATION

Out of difficulties grow miracles

Reason for request?

Who referred you? (Friend, Internet, etc.)

Medical History of beneficiary

Diagnoses of beneficiary (Please attach any or all diagnoses, scans, results etc)

Do any of the following conditions currently affect the beneficiary (Please tick)

Lack of energy		Substance abuse		Lower back pain	
Seizures/epilepsy		Moodiness		Arthritis	
Fibromyalgia		Worry		Headaches	
Pelvic pain		Anorexia/Bulimia		Osteoporosis	
Pregnancy		Sexual difficulties		Cancer/tumors	
Pacemaker		ADD/ADHD		Sprains/strains	
Anxiety		Multiple personality		Diabetes	
Anger/rage		Fear/terror		Cardiac/circulatory problems	
Depression		Psychiatric illness		High blood pressure	
Sleep difficulties		Bi-polar diagnosis		Low blood pressure	
PTSD		Blood clots		Hypoglycemia	
Suicidal thoughts		Heart attack/stroke		Hyperglycemia	

Micro Miracle FOUNDATION

Out of difficulties grow miracles

A brief of your journey

Beneficiary Wish list

Confidentiality and Indemnity

CONFIDENTIALITY CLAUSE:

Everything discussed within the confines of the time of work together shall remain confidential and shall not be divulged to any third party without your consent. If participating in group work, no identifying material to be divulged outside of the group. Non-identifying case material may be discussed during supervision with a designated mentor and for exam purposes.

I have read the above and confirm it to be true.

Signature Client:	Date: DD/MM/20YY	Signature Therapist: