CLIENT INFORMATION FORM:

TODAY'S DATE: _____

NAME: _____ DOB: _____ AGE_____ SEX: _____
ADDRESS: _____
CITY: _____ ST: _____ ZIP CODE: _____
PHONE: _____
CELL: _____ EMAIL: _____

MARITAL STATUS: S M D W

IN CASE OF EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

ARE YOU ON ANY MEDICATIONS, SUPPLEMENTS, AND/OR VITAMINS? _____

PLEASE LIST ANY PHYSICAL ISSUES YOU ARE EXPERIENCING (whether or not you believe they are related to the current issue): _____
_____
_____
_____
_____

PLEASE EXPLAIN REASONS FOR APPOINTMENT:
_____
_____
_____
_____

HOW LONG HAVE YOU BEEN EXPERIENCING THIS ISSUE: _____

DO YOU KNOW THE SOURCE OR CAUSE OF ISSUE (yes or no): _____

IF SO, PLEASE EXPLAIN: _____
_____
_____
_____
_____

WHAT SYMPTOMS ARE YOU EXPERIENCING WITH THIS ISSUE: _____
_____
_____
_____
_____

IF EXPERIENCING PHYSICAL PAIN, ON A SCALE OF 1- 10, HOW WOULD YOU RATE YOUR PAIN? _____

IF EXPERIENCING EMOTIONAL UPSET, ON A SCALE OF 1-10 HOW WOULD YOU RATE YOUR EMOTIONAL INTENSITY? _____

HAVE YOU SOUGHT PROFESSIONAL ASSISTANCE WITH THIS ISSUE BEFORE? (yes or no) _____

IF YES, WHAT TYPE OF THERAPY HAVE YOU EXPERIENCED: _____
_____

DID YOU FIND THIS OR THESE THERAPIES EFFECTIVE? (Please explain) _____
_____
_____
_____
_____

HAVE YOU EXPERIENCED ANY OTHER TYPES OF HOLISTIC HEALTH CARE? (yes or no) _____

IF YES, PLEASE LIST WHICH TYPES: (examples include: acupunctures, massage therapy, EMDR, NET, psychotherapy, etc.) _____

PLEASE EXPLAIN WHAT YOU WOULD LIKE TO ACHIEVE FROM THIS APPOINTMENT:
_____
_____
_____
_____
_____

<u>I GIVE MYSELF PERMISSION</u> TO LET GO OF ANY PHYSICAL, MENTAL, AND EMOTIONAL ISSUES THAT KEEP ME FROM LIVING THE LIFE THAT I DERSERVE.

SIGNATURE: _____ DATE: _____