Confidential Client Intake Form

Name:	Date:
Address:	Phone:
Postal Code:	Email:
Date of Birth:	Referred by:
Would you like to receive updates via email?	

Primary Concerns:	Level: **1**(hardly notice symptoms) to **10** (symptoms are unbearable)

Medications/Remedies/Supplements & Reason for taking:

Significant Accidents/Injuries:

Please place an X beside any conditions that apply (past or present):		
Cancer	Varicose Veins	Allergies:
Heart Disease	H/L Blood Pressure	Surgery:
Diabetes	Paralysis	Genetic Disorders:
Stroke	TMJ Dysfunction	Phobias:
Epilepsy	Arthritis	

Place an X beside any symptoms that you experience:

Headache
Faintness/Dizziness
Tightness in Jaw
Weak body parts
Smoking (#/day__)
Nervousness
Poor Appetite
Excessive Urination
Grinding of Teeth
Heavy feeling in limbs
Blurriness of vision
Constipation
Loose Bowel Movements
Irritated Bowel
Pains in heart/chest
Indigestion
Insomnia
Fatigue
Cold in hands and feet
Lower Back pain
Shoulder/neck pain
Carpal tunnel syndrome
Menstrual Irregularities
Other:

Are you pregnant?

Place an X beside any areas below that you would like improvement in:

Negative self-talk, self-sabotage
Belief in ability to achieve goals
Ability to relax
Ability to use dreams as mental tool for problem solving
Eliminate procrastination
Ability to reach ideal weight
Personal magnetism
Strengthen memory/concentration
Breaking old habits
Release negative events
Ability to align body/mind for self-healing
Ability to take action
Increase learning ability
Beneficial, relationships
Prosperity (attract what you choose)
Attitude and skills at work
Self-Esteem
Youthful Vitality

Below, please describe what you would like to accomplish with these treatments?