

CLIENT INFORMATION FORM



TODAY'S DATE: _____

NAME: _____ DOB: _____ AGE: _____ SEX: Male Female
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
PHONE NUMBER: (____) _____ CELL PHONE: (____) _____
EMAIL: _____ MARITAL STATUS: S M D W
IN CASE OF EMERGENCY CONTACT: NAME _____ PHONE (____) _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

DO YOU HAVE A PACEMAKER? (circle) YES NO

LIST ANY MEDICATIONS, SUPPLEMENTS AND/OR VITAMINS _____

PLEASE LIST ANY PHYSICAL ISSUES YOU ARE EXPERIENCING (whether or not they relate 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, RATE YOUR PAIN? _____

IF EXPERIENCING EMOTIONAL UPSET, ON A SCALE OF 1-10, 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 THESE EFFECTIVE? (Please explain) _____

HAVE YOU EXPERIENCED OTHER TYPES OF HOLISTIC HEALTH CARE: (yes or no) IF YES, PLEASE LIST WHICH TYPES: (examples include: acuunctures, massage therapy, EMDR, NET, psychotherapy, etc...) _____

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

I GIVE MYSELF PERMISSION TO LET GO OF ANY PHYSICAL, MENTAL, AND EMOTIONAL ISSUE THAT KEEPS ME FROM LIVING THE LIFE THAT I DERSERVE.

SIGN HERE: _____ DATE: _____