

CONFIDENTIAL CLIENT CASE HISTORY AND INTAKE FORM

NAME:	DATE:
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ADDRESS:	PHONE:
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POSTAL CODE:	EMAIL:
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DATE OF BIRTH:	REFERRED BY:
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WOULD YOU LIKE TO RECEIVE UPDATES VIA EMAIL?
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PRIMARY CONCERNS:	LEVEL: 1 (HARDLY NOTICE SYMPTOMS) TO 10 (SYMPTOMS ARE UNBEARABLE):
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A:	LEVEL:
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B:	LEVEL:
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C:	LEVEL:
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MEDICATIONS/REMEDIES/SUPPLEMENTS & REASON FOR TAKING:

SIGNIFICANT ACCIDENTS/INJURIES:

REIKI BY

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:

<p>HEADACHE FAINTNESS/DIZZINESS TIGHTNESS IN JAW WEAK BODY PARTS SMOKING (#/DAY__) NERVOUSNESS POOR APPETITE EXCESSIVE URINATION GRINDING OF TEETH</p>	<p>HEAVY FEELING IN LIMBS BLURRING OF VISION CONSTIPATION LOOSE BOWEL MOVEMENTS IRRITATED BOWEL PAINS IN HEART/CHEST INDIGESTION INSOMNIA FATIGUE</p>	<p>COLD IN HANDS AND FEET LOWER BACK PAIN SHOULDER/NECK PAIN CARPEL TUNNEL SYNDROME MENSTRUAL IRREGULARITIES OTHER: ARE YOU PREGNANT?</p>
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PLACE AN X BESIDE ANY AREAS BELOW THAT YOU WOULD LIKE IMPROVEMENT IN:

<p>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</p>	<p>ABILITY TO REACH IDEAL WEIGHT PERSONAL MAGNETISM STRENGTHEN MEMORY/CONCENTRATION BREAKING OLD HABITS RELEASE NEGATIVE EVENTS ABILITY TO ALIGN BODY/MIND FOR SELF-HEALING</p>	<p>ABILITY TO TAKE ACTION INCREASE LEARNING ABILITY BENEFICIAL, RELATIONSHIPS PROSPERITY (ATTRACT WHAT YOU CHOOSE) ATTITUDE AND SKILLS AT WORK SELF-ESTEEM YOUTHFUL VITALITY</p>
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BELOW, PLEASE DESCRIBE WHAT YOU WOULD LIKE TO ACCOMPLISH WITH THESE TREATMENTS: