Integrative Wellness Coaching

with

C. Lynette Lundy

CONFIDENTIAL CLIENT CASE HISTORY AND 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):
A:	LEVEL:
B:	LEVEL:
C:	LEVEL:

MEDICATIONS/REMEDIES/SUPPLEMENTS & REASON FOR TAKING:

SIGNIFICANT ACCIDENTS/INJURIES:

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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 CARPEL 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: