

CONFIDENTIAL CLIENT CASE HISTORY & INTAKE FORM

NAME: _____

DATE: _____

ADDRESS: _____

PHONE: _____

ZIP 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:

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	HEAVY FEELING IN LIMBS	COLD IN HANDS AND FEET
FAINTNESS/DIZZINESS	BLURRING OF VISION	LOWER BACK PAIN
TIGHTNESS IN JAW	CONSTIPATION	SHOULDER/NECK PAIN
WEAK BODY PARTS	LOOSE BOWEL MOVEMENTS	CARPEL TUNNEL SYNDROME
SMOKING (#/DAY__)	IRRITATED BOWEL	MENSTRUAL IRREGULARITIES
NERVOUSNESS	PAINS IN HEART/CHEST	OTHER:
POOR APPETITE	INDIGESTION	
EXCESSIVE URINATION	INSOMNIA	
GRINDING OF TEETH	FATIGUE	ARE YOU PREGNANT?

PLACE AN X BESIDE ANY AREAS BELOW THAT YOU WOULD LIKE IMPROVEMENT IN:

NEGATIVE SELF-TALK, SELF-SABOTAGE	ABILITY TO REACH IDEAL WEIGHT	ABILITY TO TAKE ACTION
BELIEF IN ABILITY TO ACHIEVE GOALS	PERSONAL MAGNETISM	INCREASE LEARNING ABILITY
ABILITY TO RELAX	STRENGTHEN	BENEFICIAL, RELATIONSHIPS
ABILITY TO USE DREAMS AS MENTAL TOOL FOR PROBLEM SOLVING	MEMORY/CONCENTRATION	PROSPERITY (ATTRACT WHAT YOU CHOOSE)
ELIMINATE PROCRASTINATION	BREAKING OLD HABITS	ATTITUDE AND SKILLS AT WORK
	RELEASE NEGATIVE EVENTS	SELF-ESTEEM
	ABILITY TO ALIGN BODY/MIND FOR SELF-HEALING	YOUTHFUL VITALITY

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BY JEANTTE
STILLINGER

BELOW, PLEASE DESCRIBE WHAT YOU WOULD LIKE TO ACCOMPLISH WITH THESE TREATMENTS: