TheAssist@theassist.life
Confidential Client ASSISTment 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*	

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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?

_____

_____

_____

_____

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