Hints of Tomorrow - Client Interview

Name_____ DOB_____ Date_____

Address_____

Phone Number_____ Email_____

Occupation_____ Referred by_____

Reason for appointment_____

Personal Stress_____

_____

Work Related
Stress_____

_____

Stress Reduction/Relaxation/Exercise_____

_____

Meditation_____Daily_____ Times/Week_____ Occasionally_____ Never_____

Journal_____Daily_____ Times/Week_____ Occasionally_____ Never_____

Current Health Care Providers_____

_____

Current Medications_____

_____

Significant Medical/Sleep History_____

Smoke_____Drink Alcohol_____ Weekly_____ Occasionally_____

Yes/No
Pace Maker_____ Hearing Aide_____ Broken Bones_____ Spinal Cord Stim _____

Client Signature_____Date_____

Practitioner Signature_____Date_____