CLIENT INTAKE FORM

Name: ____ Phone: ____________________________________

Address:____

City/Province/Postal: ____

Email Address:____ DOB:_____________________________________

Occupation: ___________________________________ Does this fulfill you? Y/N

Emergency Contact: ___________________________________ Phone: ______________________________

Please explain reason for appointment:____

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How long have you been experiencing this? ____

Do you know the source or cause of this issue? YES/NO

Please explain if yes: ____

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What symptoms are you experiencing as a result of this issue? ______________________________________

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If experiencing physical pain, please rate the pain on a scale of 1-10 (10 being unbearable)

1 2 3 4 5 6 7 8 9 10

Have you sought other professional assistance? (Please list what's worked and what hasn't)

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Please explain what you would like to achieve from this session: ____________________________________

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