CLIENT HISTORY

Name: ____

ADDRESS: ____ CITY: _______________________________

STATE: ___________________________________ ZIP:_______________ CELL PHONE:_________________________

DATE OF BIRTH:____________________ AGE:____ SEX:_____ MARITAL STATUS:______________________________

OF CHILDREEN:_____ EMPLOYER: _____________________ JOB TITLE: ____________________________________

MEDICAL HISTORY

HAVE YOU BEEN UNDER A DOCTOR'S CARE IN THE LAST YEAR? YES: _____ NO: _____

IF YES TO THE ABOVE QUESTION, PLEASE PROVIDE REASON(S): ____

HAVE YOU EVER BEEN TREATED FOR ANY EMOTIONAL TRAUMA OR ISSUES: ___________________________________

ARE YOU CURRENTLY RECEIVING TREATEMENT/COUNSELING? ____

HAVE YOU EVER BEEN TREATED FOR: HEART __________________ DIABETES ____________ EPILEPSY _____________

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES: __________ NO: ________

IF YES, WHAT MEDICATION? ____

REASON FOR MEDICATION: ____

WHAT CHANGES WOULD YOU LIKE TO MAKE? ____

____

WHY DO YOU WANT TO MAKE THESE CHANGES? ____

____

HOW DO YOU SEE YOURSELF MAKING THESE CHANGES? ____

____

HOW WILL YOUR LIFE BE DIFFERENT WHEN YOU MAKE THESE CHANGES? (22 REASONS)

____

____

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SIGNATURE: DATE: