

## Inner Balance & Wellness Health Profile

### For Emotion, Body & Belief Code Sessions

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Current Age: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

What are your primary concerns/issues?

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Scan Body from head to toe and notice discomfort in any area.

Describe w/ location and rate (0 is no pain and 10 is extreme pain) below:

Head/Face: \_\_\_\_\_ Rating: \_\_\_\_\_

Neck: \_\_\_\_\_ Rating: \_\_\_\_\_

Chest: \_\_\_\_\_ Rating: \_\_\_\_\_

Back: \_\_\_\_\_ Rating: \_\_\_\_\_

Shoulders: \_\_\_\_\_ Rating: \_\_\_\_\_

Arms: \_\_\_\_\_ Rating: \_\_\_\_\_

Wrists/Hands/Fingers: \_\_\_\_\_ Rating: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Rating: \_\_\_\_\_

Hips/Pelvis: \_\_\_\_\_ Rating: \_\_\_\_\_

Glutes: \_\_\_\_\_ Rating: \_\_\_\_\_

Legs/Knees: \_\_\_\_\_ Rating: \_\_\_\_\_

Ankles/Feet/Toes: \_\_\_\_\_ Rating: \_\_\_\_\_

(if you do not have enough room to write, please use the additional information section on page 2)

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**Please indicate any mental/emotional areas of concern by circling Y or N:**

Anger	Y or N	Nervousness	Y or N	Sleep issues	Y or N
Fear	Y or N	Worry	Y or N	Holding grudges	Y or N
Anxiety	Y or N	Insecurity	Y or N	Lack of motivation	Y or N
Depression	Y or N	Limiting Beliefs	Y or N	Disconnected	Y or N
Sadness	Y or N	Self-Sabotage	Y or N	Guilt or Shame	Y or N

**Stress level (0 is none and 10 is high): \_\_\_\_\_**

**Are you currently pregnant: (circle) Y or N**

**Any other information you think would be important to communicate:**

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