All's Well Therapy, LLC
Addressing the root causes of symptoms through energy balancing
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Client Intake Form

Client Summary

Name	
Address	
E-mail address	
Phone #: Home	
Phone #: Cell	
Date of Birth	
Emergency Contact Name	
Emergency Contact Phone #	
Names/Ages of Children	
Primary Care Physician (PCP)	
PCP Phone Number	
Additional Healthcare Provider(s)	

Current Health Issues/Diagnoses

Issue/Dx	Under Care of Physician? Who?	Medication? Name?

Top Five Health/Wellness Issues That You'd Like to Address Through Our Work Together

Issue	Description of Symptoms	Current severity/10

My signature below indicates that the above information is accurate and complete.

Signature: _____

Date signed: _____

If the client is a minor, the signature of a parent or guardian is required.

Signature: _____ Date signed: _____