Intuitive Self Healing
Client Intake Form

Name____ Date of Birth_________________

Street Address____

City, State, ZIP____

Please make a notation by the <u>best</u> phone number to reach you at:

Home____

Cell____

Work____ Occupation__________________

Email ____(Will only be used for I.S.H. communications)

How did you hear about Intuitive Self Healing?____________________________________

What can we help you with today: (Mark all that apply)

Preventative Care   Health Concerns___________________________________

Cleanse Detox Program   Other____

Are you currently under that care of a medical or therapeutic practitioner?   Y   N

If yes, please explain ____

____

Are you experiencing any <u>high stress</u> in your life? (Please circle any that apply)

Loss of a loved one	Divorce/Separation	Family dispute
Family illness	Bankruptcy	Loss of a job

Any other change in your life____

Health Questionnaire

What actions are you taking (or have taken) to achieve your desired wellness?

____

____

Please mark any body systems that you have a concern, condition or complaint with:

Immune	Skeletal	Urinary
Digestive	Muscular	Nervous
Endocrine (hormonal)	Circulatory	Emotional

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Do you have any issue or conditions with your vision or hearing? ____________________

____

Do you know your blood type? A B AB O

Do you have any of the following emotional issues?

Anxiety	Depression	Anger
Chemical Dependency	Eating Disorders	Other:__________________

Are any of the above conditions:

Getting progressively worse	Interfering with work
Interfering with sleep	Causing trouble with your daily routine

Explain: ____

____

____

Are you currently taking any:

Prescription Medications: ______________________________

____

Nutritional Supplements: ______________________________

____

____

Please list any known Allergies ______________________________

____

Please list any surgical procedures ______________________________

____

Daily Routine

Do you follow a vegetarian, vegan, or specialized diet? ______________________________

Do you exercise on a regular basis? Please describe ______________________________

____

Do you drink caffeinated beverages? What kind and how often ______________________________

How many alcoholic beverages do you drink per week? ______________________________

Do you drink 64oz of water every day? Y N

Do you smoke? Y N Are you trying to quit? Y N

What steps are you taking?______________________________

Do you eat nutritionally balanced meals? Y N

How many times per week do you eat processed foods? ______________________________

How many hours of uninterrupted sleep do you get? *6 or less* *7 hours* *8 or more*

If *6 or less* please explain? ______________________________

Do you carve out uninterrupted me time on a weekly basis? Y N

If yes what does it look like, if no…why not ______________________________

____

By signing below, I certify that I have read and understand this document and that the information that I have provided is accurate. I understand that Leah Buysse is a Holistic Health Practitioner/Intuitive Healer, NOT a medical doctor, and that she will NOT diagnose or prescribe medication. I acknowledge and invite her to create a *holistic, intuitive* program to assist me in achieving my personal health goals, and triggering the body's innate ability to heal itself. I understand that I am here to learn about nutrition, better health practices and lifestyle systems that should be used in conjunction with conventional medicine. These programs are not to be used as a medical substitute.

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Signature of patient Date

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Signature of guardian if under 18 Date