

Confidential Client Case History and Intake Form

Name:	Date:
Address:	Phone:
Postal Code:	Email:
Date of Birth:	Referred by:
Would you like to receive updates via email?	

Primary Concerns:	Level: 1 (hardly notice symptoms) to 10 (symptoms are unbearable)
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Medications/Remedies/Supplements & Reason for taking:

Significant Accidents/Injuries:

Please place an X beside any conditions that apply (past or present):		
Cancer	Varicose Veins	Allergies:
Heart Disease	H/L Blood Pressure	Surgery:
Diabetes	Paralysis	Genetic Disorders:
Stroke	TMJ Dysfunction	Phobias:
Epilepsy	Arthritis	

Place an X beside any symptoms that you experience:

- | | | |
|---------------------|------------------------|--------------------------|
| Headache | Heavy feeling in limbs | Cold in hands and feet |
| Faintness/Dizziness | Blurriness of vision | Lower Back pain |
| Tightness in Jaw | Constipation | Shoulder/neck pain |
| Weak body parts | Loose Bowel Movements | Carpel tunnel syndrome |
| Smoking (#/day__) | Irritated Bowel | Menstrual Irregularities |
| Nervousness | Pains in heart/chest | Other: |
| Poor Appetite | Indigestion | |
| Excessive Urination | Insomnia | Are you pregnant? |
| Grinding of Teeth | Fatigue | |

Place an X beside any areas below that you would like improvement in:

- | | | |
|--|---|--------------------------------------|
| Negative self-talk, self-sabotage | Ability to reach ideal weight | Increase learning ability |
| Belief in ability to achieve goals | Personal magnetism | Beneficial, relationships |
| Ability to relax | Strengthen memory/concentration | Prosperity (attract what you choose) |
| Ability to use dreams as mental tool for problem solving | Breaking old habits | Attitude and skills at work |
| Eliminate procrastination | Release negative events | Self-Esteem |
| | Ability to align body/mind for self-healing | Youthful Vitality |
| | Ability to take action | |

Below, please describe what you would like to accomplish with these treatments?

