Name:

Address:

Phone:

Email:

Date of Birth:

Reason for visit:

When did you first start experiencing these symptoms?

Health history:

Current medications (pharmeceuticals):

Current supplements (herbal, mineral, etc):

Describe your weekly exercise regime (if any):

Describe your current diet:

Do you currently have a spiritual/religious/prayer practice?

What emotions would you like to work on today?

Do you currently have any health issues?

Do you have any chronic health issues?

What other therapies or significant growth experiences are you now undergoing?

What are you passionate about?

What is your strongesy negative emotions towards currently?

Digestive System

Diarrhea

Constipation

Bloating/gas

Heartburn

Ears

Itchy

Ringing

Drainage

Infections

Emotions

Mood swings

Anxiety/fears/nervousness

Anger/irritability

Depression

Despair

Disinterested