

Client Intake Form

Name _____ **Date** _____

Address

Street	City	Postal Code
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Contact

Home/Cel Phone	Work Phone	E-mail
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Occupation _____ **Birth Date** _____

How are you feeling today?

Physical Illnesses (Please note any diseases, accidents, operations, and imbalances)

Mental and Emotional Challenges (Please note any diagnosed psychological conditions and known mental and/or emotional challenges)

Do you generally express emotions freely?

Please list any medications (pharmaceutical and/or herbal) you are currently taking

Spirituality (List your spiritual/religious practices. How connected do you feel to Spirit?)

Please describe what you know about your birth. (Eg. Hospital, fast, late, induced, drugs, caesarean, forceps, breech, twins, other complications during and surrounding birth, etc)

To what extent do the following issues affect you today?

Never Sometimes Frequently Always

Addictions

- Smoking
- Drinking
- Food
- Drugs

Physical Symptoms

- Tiredness
- Headaches
- Stomach Problems
- Sleeplessness
- Pain

Emotions

- Anxiety/Worry
- Anger
- Isolation
- Depression
- Sadness
- Grief
- Fear
- Do you over-react

Challenges with

- Self
- Family
- Friends & Others
- Work

What are your intentions for this session?
