

CLIENT INTAKE FORM



Date: _____

First name: _____ Initial: _____ Last name: _____

Address: _____ City: _____ Postal Code: _____

Please list the numbers at which we may contact you.

E-Mail: _____ Skype name: _____

Home phone: _____ Cell Phone: _____

This is a confidential record of your medical history and will be kept in this office.

Information contained here will not be released to any person except when you have authorized us in writing to do so, or when required by law.

Please complete this questionnaire as thoroughly as possible.

What symptoms are you experiencing that you suspect may be related to the Zeal Point Chakra?

If this is a chronic illness, how long have you had this condition?

Have you sought prior treatment for this condition: YES NO

If yes, what type of treatment did you receive? _____

If you are female, are you currently pregnant? YES NO

(Please advise us if you become pregnant during our time working together)

Are there other health concerns that I should be made aware of?

PERSONAL HEALTH HABITS

Smoker? YES NO Amount/day? _____ Years smoked? _____ Year stopped? _____

Are you exposed to smoking at home? YES NO

Are you exposed to smoking at work? YES NO

Alcohol use? YES NO Type: _____ Frequency: _____

Recreational drug use? YES NO Type: _____ Frequency: _____

Caffeine use ? YES NO Type: _____ Frequency: _____

Are there any food groups that you avoid? YES NO

What? _____ Why? _____

Are you frequently exposed to animals? YES NO What type? _____

Are you regularly exposed to toxins or other hazards? YES NO

What kind? _____

Do you exercise regularly? YES NO Type: _____ Frequency: _____

How many hours do you sleep per night? _____ Do you wake rested: YES NO

How many hours do you work each day? _____ Do you do shift work? YES NO

How is your general health? _____

What level of personal stress are you experiencing in your daily life right now?

Minimal Average Considerable Unbearable

The main stressor is:

Financial Job related Marriage Health

Interpersonal Unfulfilled expectations Family Spiritual

Other _____

What do you do to deal with stress? _____

Anything else you'd like to add: _____

