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 have an emotional source?

_____

_____

_____

_____

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: _____

_____

_____

_____

_____

_____

Revised: Jan 8, 2019