

CLIENT INTAKE FORM
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Name _____ Date of Visit _____

Address _____

Date of Birth _____ Height _____ Weight _____

Occupation _____ Work Phone _____ Home Phone _____

Relationship Status _____ Children _____ Referred By _____

Therapist (name, address, phone) _____

Physician (name, address, phone) _____

Therapeutic/Spiritual Growth Experience _____

Reason for Visit _____

Date of Onset _____ Sudden _____ Slow _____

Previous Treatment _____

Antibiotics/Medications Currently Taken _____

Non-Medicinal Drugs Currently Taken _____

Alcohol Intake _____ Tobacco/Cigarettes _____ Daily Fluid Intake (Not Alcohol) _____

General Type of Diet _____

Exercise _____

Vision _____ Wear Glasses/Contacts _____ Smell _____ Hearing _____ Taste _____

Accidents/Injuries _____

Surgeries _____

Do you have or have you had: (Please mark "C" to indicate current symptoms or "P" for symptoms you have had in the past.)

- | | | | | |
|---------------------------------------|---------------------------------------|--|--|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fungal Infections | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fever | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Flatulence | <input type="checkbox"/> Depression | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dysentery | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Female Organ Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Measles | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pancreas Problems |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Allergies | <input type="checkbox"/> German Measles | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Herpes Simplex I | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Herpes Simplex II | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Hypoglycemia |

What are your goals/expectations from this healing today? Long range?

