CLIENT INTAKE FORM

Name_____ Date _____

Address_____

Email 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)_____

GeneralTypeDiet_____Exercise_____

Vision_____ wear glasses/contacts? _____Smell _____Hearing_____Taste_____

Accidents/Injuries_____

Surgeries_____

Other information you would like me to know which will be helpful in my treating you?

_____

_____

_____

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

Phoebe Allwell BHS Energy Medicine Therapist
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