

**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?

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

Phoebe Allwell BHS Energy Medicine Therapist

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