WHOLISTIC HEALTHCARE

tapping your way to freedom...

CLIENT INTAKE FORM (Strictly Confidential)

Name: _____ Date: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

Preferred Contact Method: Text Phone Call Email

Marital Status: _____ Age: ____ Occupation: _____

Children (ages): _____ Siblings (ages): _____ Time Zone: _____ # of Hours Purchased: _____

Eutaptics Student Level: _____

List your major challenges you'd like to overcome in order of importance to you, and how long you have been experiencing each one:

1. _____
2. _____
3. _____
4. _____

List 4 things you want more of in your life:

1. _____
2. _____
3. _____
4. _____

If you have health challenges, what are they?

If so, what are the most contributing factors? (Diet, lifestyle, relationships, stress (topic), finances, work – Rank in order.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Are you under the care of a physician and if so, what for?

Are you currently or have you in the past used the services of a chiropractor, acupuncturist, holistic health or nutritional consultant?

List any current medications you are taking and how long you've been taking them:

If true, finish this sentence: "I have not been well since" . . .

Do you have pain in any part of your body? If so, where and for how long?

Have you had any of the following: surgeries, shocks, traumas, injuries, falls, abuse?

Do you consume any of the following? If yes, indicate how much:

Alcohol: _____ Cigarettes: _____

Coffee: _____ Recreational Drugs: _____

On a scale of 1-10, how committed are you to addressing your Problem/Pain/Issue/Symptom?

Who were you closest to growing up?

What part did they play?