**Confidential Client Case History and Intake Form**

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| --- | --- |
| Name: | Date: |
| Address: | Phone: |
| Postal Code: | Email: |
| Date of Birth: | Referred by: |
| Would you like to receive updates via email? | |

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| --- | --- |
| **Primary Concerns**: | Level: **1**(hardly notice symptoms) to **10** (symptoms are unbearable) |
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| **Medications/Remedies/Supplements & Reason for taking:** |
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| **Significant Accidents/Injuries:** |
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| --- | --- | --- |
| **Please place an X beside any conditions that apply (past or present):** | | |
| Cancer | Varicose Veins | Allergies: |
| Heart Disease | H/L Blood Pressure | Surgery: |
| Diabetes | Paralysis | Genetic Disorders: |
| Stroke | TMJ Dysfunction | Phobias: |
| Epilepsy | Arthritis |  |

**Place an X beside any symptoms that you experience:**

|  |  |  |
| --- | --- | --- |
| Headache  Faintness/Dizziness  Tightness in Jaw  Weak body parts  Smoking (#/day\_\_)  Nervousness  Poor Appetite  Excessive Urination  Grinding of Teeth | Heavy feeling in limbs  Blurriness of vision  Constipation  Loose Bowel Movements  Irritated Bowel  Pains in heart/chest  Indigestion  Insomnia  Fatigue | Cold in hands and feet  Lower Back pain  Shoulder/neck pain  Carpel tunnel syndrome  Menstrual Irregularities  Other:  Are you pregnant? |

**Place an X beside any areas below that you would like improvement in:**

|  |  |  |
| --- | --- | --- |
| Negative self-talk, self-sabotage  Belief in ability to achieve goals  Ability to relax  Ability to use dreams as mental tool for problem solving  Eliminate procrastination | Ability to reach ideal weight  Personal magnetism  Strengthen memory/concentration  Breaking old habits  Release negative events  Ability to align body/mind for self-healing  Ability to take action | Increase learning ability  Beneficial, relationships  Prosperity (attract what you choose)  Attitude and skills at work  Self-Esteem  Youthful Vitality |

**Below, please describe what you would like to accomplish with these treatments?**

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