**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:**

|  |  |  |
| --- | --- | --- |
| HeadacheFaintness/DizzinessTightness in JawWeak body partsSmoking (#/day\_\_)NervousnessPoor AppetiteExcessive UrinationGrinding of Teeth | Heavy feeling in limbsBlurriness of visionConstipationLoose Bowel MovementsIrritated BowelPains in heart/chestIndigestionInsomniaFatigue | Cold in hands and feetLower Back painShoulder/neck painCarpel tunnel syndromeMenstrual IrregularitiesOther:Are you pregnant? |

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

|  |  |  |
| --- | --- | --- |
| Negative self-talk, self-sabotageBelief in ability to achieve goalsAbility to relaxAbility to use dreams as mental tool for problem solvingEliminate procrastination | Ability to reach ideal weightPersonal magnetismStrengthen memory/concentrationBreaking old habitsRelease negative eventsAbility to align body/mind for self-healingAbility to take action | Increase learning abilityBeneficial, relationshipsProsperity (attract what you choose)Attitude and skills at workSelf-EsteemYouthful Vitality |

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

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