

## **Confidential Client Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Email address \_\_\_\_\_

Birth Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

Primary concerns you would like addressed \_\_\_\_\_

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(Use back of paper if needed.)

## **General History**

Have you ever had a Spiritual Healing before? Yes No

Do you Exercise? Yes No What kind? \_\_\_\_\_ How Often? \_\_\_\_\_

How much caffeine do you have? Coffee \_\_\_\_\_ Teas \_\_\_\_\_ Sodas \_\_\_\_\_

How much alcohol do you drink? Per week \_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_

Do you smoke? Yes No

List any chronic conditions you have. \_\_\_\_\_ How long? \_\_\_\_\_

Are you on any medication? Please list: \_\_\_\_\_

Women – Any children? Yes No If so, how many \_\_\_\_\_ Miscarriages? Yes No

Any Surgeries/Traumas? Please list, including date: \_\_\_\_\_