MY PATH OF HEALING

integrative healing & transformation

RETURNING CLIENT INTAKE FORM

Update contact information if it's changed from last visit

Name _____ Date _____

Address _____ Date of Birth _____ Phone _____

Height _____ Weight _____ Occupation _____

Relationship Status _____ Number of Children _____

Referred by_____ Emergency Contact _____

Reason for visit _____

Date of onset_____ Sudden _____ Slow _____

Contributing factor for presenting complaint _____

Current/Previous treatment (for above)_____

Are you on any medication/supplements? Yes No If yes, which ones?_____

_____

Current Therapies/Treatments _____

Would you like to share anything else or add any additional comments?_____

_____

_____

_____

Printed Name: _____

Client Signature: _____

Date: _____

Phone: _____

Email: _____