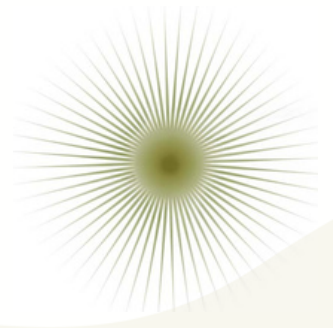


MY PATH OF HEALING

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: _____