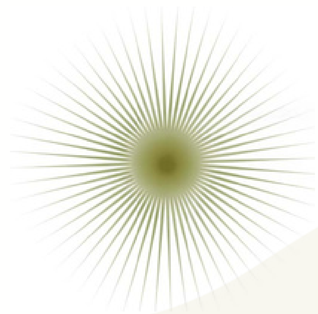

MY PATH OF HEALING

integrative healing & transformation

CLIENT INTAKE FORM

Name ______________________ Date ____________ Email ____________

Address ______________________ Date of Birth __________ Phone __________

Height __________ Weight __________ Occupation ______________________

Relationship Status ____________ Number of Children __________

Referred by____________ Emergency Contact ______________________________

How did you learn about us? ______________________

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 ____

Describe your spiritual growth and experiences. ______________________________

____

____

Please list any traumatic or life threatening events and at what point in your life they occurred.

____

____

____

What do you hope to gain from this healing today and long-term? ______________________

____

____

____

Would you like to share anything else with Tatiana? ______________________________

____

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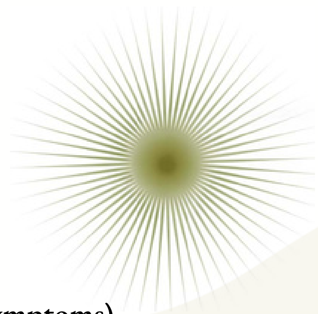

Do you have or have you had:
(Mark C for current symptoms; P for past symptoms; CH for chronic symptoms)

- Depression
- Anxiety
- Eating Disorder
- Mood Swings
- Substance Abuse
- Headaches
- TMJ
- Jaw pain
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Whooping cough
- Epilepsy
- Dizziness
- Insomnia
- Migraines
- Headaches
- Stroke
- Lyme disease
- Constipation
- Kidney Stones
- Diabetes
- Diarrhea
- Gastritis
- Hepatitis
- Hypoglycemia
- Jaundice
- Liver Disorder
- Ulcers
- Angina
- Heart Attack
- Heart Failure
- Adrenal
- Insufficiency
- Pituitary
- Dysfunction
- Hyperthyroid
- Hypothyroid
- Mononucleosis
- Epilepsy
- Dizziness
- Musculo-Skeletal
- Athritis
- Back Pain
- Carpal Tunnel
- Gout
- Skin Disorder (type):
- AIDS/HIV
- Allergies
- Cancer (type):__________
- Fatigue
- Fever (chronic)
- Fibromyalgia
- Fungal Infection
- Herpes (type): __________
- STD (type): __________
- Endometriosis
- Bladder Infection
- Other: __________

____
____
____
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