Basic Intake Form

Name of Client: Referred by:

Address: Email:

Home phone: Work Phone:

Date, place, and exact time of birth:

Siblings/Children/Spouse (Age and Relationship):

Occupation:

Are you currently under the care of a healer, doctor, therapist, acupuncturist, homeopath, naturopath or other medical or health professional? *If so, please list which one/s and also state for what condition/s.*

Please list condition(s) you are wanting to heal:

Condition Since Causes

Medications/Supplements/Remedies you currently take:

Medication/Other	Since	Adverse effects

Other Treatments you are currently following:

Treatment	Since	Results

Which of the following conditions have you or any blood relation had? Indicate with an "s" for self, "f" for family member.

1 Abscesses Heart Disease Rubella Stroke
2 Alcoholism Hepatitis Prostatis Wart
3 Allergies Herpes Rheum Fever Whooping Cough
4 Amnesia Kidney/Bladder Scarlet Fever Worms
5 Arthritis/gout Leukemia Sexual Abuse Yellow Fever
6 Cancer Malaria Skin Disease Asthma
7 Cold Sores Measles Strep Throat Insanity
8 Depression Miscarriage Sinusitis Paralysis
9 Diabetes Mono. Sunstroke Anemia
10 Emphysema Mumps Syphilis Bleeding
11 Epilepsy Parasites Tonsillitis Drug Addiction
12 Gonorrhea P.I.D. Tuberculosis Hi Blood Pressure

What other major conditions have you had?

Condition	When	Complications

Are there any conditions after which you have never been totally well again, or have been more severe than usual in the last year? Which ones?

What surgeries have you had?

Surgery	When	Complications

Any major injuries?

Injury	When	Long-term effects

How much of the following substances are you using?

Cigarettes: Y/N	Frequency:	Period of use: _____yrs
Alcohol: Y/N	Frequency:	Period of use: _____yrs
Drugs: Y/N	Frequency:	Period of use: _____yrs

Have you ever had a mental illness? If so, please provide further information.