



HOPE OVERCOMES
— HOLISTIC EMOTIONAL WELLNESS —

Client Information Form

Date: _____
Name: _____ DOB: _____ Age: _____ Sex: Male Female
Address: _____ City: _____ State: _____ Zip: _____
Phone: (____) _____ Cell: (____) _____
Email: _____ Marital Status: S M D W
In case of emergency: Name _____ Phone (____) _____

Whom may we thank for referring you: _____

Do you have any implants that react to magnet? (circle) Yes No

List and medications, supplements and/or vitamins (use back of page if you have more)

NAME	DOSAGE	TAKEN FOR

Please list any physical issues you are experiencing (whether or not they relate to the current issue): _____

Please explain reasons for appointment: _____

How long have you been experiencing this issue: _____

Do you know the source or cause of issue (yes or no) If so please explain: _____

What symptoms are you experiencing with this issue: _____

If experiencing physical pain, on a scale of 1-10 rate your pain? _____

If experiencing emotional upset, on a scale of 1-10. Rate your emotional intensity? _____

Have you sought professional assistance with this issue before? (yes or no) If yes, what type of therapy have you experienced: _____

Did you find these effective? (Please explain) _____

Have you experienced other types of holistic health care: (yes or no) If yes, please list which types: (examples include: acupunctures, massage therapy, EMDR, NET, psychotherapy, etc...)

Please explain what you would like to achieve from this appointment: _____

I give myself permission to let go of any physical, mental and emotional issue that keeps me from living the life that I love.

Signature: _____ Date: _____