insight body therapies

EMOTIONAL FREEDOM TECHNIQUE CLIENT INFORMATION (kept confidential)

Name: Date:

Address, including zip: email address:

Daytime phone: Evening phone:

Emergency contact and phone:

Date of Birth: Age:

Marital Status:

❏ Single ❏ Married ❏ Living with ❏ Widowed ❏ Separated ❏ Divorced

Number of children: Occupation:

Hobbies/Recreation:

By whom were you referred?

List all physical/emotional complaints:

Briefly describe the health concern(s) you would like to address in this session. Note when it began, and if there was any trauma at the onset. Rate the severity on a scale of 0 (nonexistent) to 10 (all time worst).

What do you feel caused this problem?

What other approaches have you tried for the problem(s) and how well did they work?

Are you currently in a course of treatment (doctor, therapist, alternative health care, etc.)?

List medications taken and what they're for:

Please list any chronic condition-- headaches, indigestion, insomnia, allergies, etc.:

What is your daily intake of:

Pure water? _____ 8-oz glasses Fruit juice? _____ Soft drinks? _____

Tea/coffee? _____ cups Alcohol? _____ Tobacco? _____

On a scale of 1-10 what is your daily vitality?

Do you experience any physical pain you haven't already mentioned? If yes, explain.

List history of accidents, injuries, surgeries, major illness (with dates):

Any other information you feel may be pertinent to your session?