



Integra Healing Arts

Confidential Client Case History and Intake Form

Name:	Date:
Address:	Phone:
Postal Code:	Email:
Date of Birth:	Referred by:

Primary Concerns and Level of Pain/Discomfort 1 (hardly notice symptoms) to 10 (symptoms unbearable)

Medications/Remedies/Supplements & Reason for Taking

Significant Accidents/Injuries

Please check any conditions that apply (past or present) & provide information on the items below.		
<input type="checkbox"/> Cancer	<input type="checkbox"/> Varicose Veins	Allergies:
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> H/L Blood Pressure	Surgeries:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Paralysis	Genetic Disorders:
<input type="checkbox"/> Stroke	<input type="checkbox"/> TMJ Dysfunction	Phobias:
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	Other:

Please check any symptoms that you experience.

- | | | |
|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Heavy feeling in limbs | <input type="checkbox"/> Cold in hands and feet |
| <input type="checkbox"/> Faintness/Dizziness | <input type="checkbox"/> Blurriness of vision | <input type="checkbox"/> Lower Back pain |
| <input type="checkbox"/> Tightness in Jaw | <input type="checkbox"/> Constipation | <input type="checkbox"/> Shoulder/neck pain |
| <input type="checkbox"/> Weak body parts | <input type="checkbox"/> Loose Bowel Movements | <input type="checkbox"/> Carpel tunnel syndrome |
| <input type="checkbox"/> Smoking (#/day__) | <input type="checkbox"/> Irritated Bowel | <input type="checkbox"/> Menstrual Irregularities |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pains in heart/chest | |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Indigestion | <input type="checkbox"/> I am/may be pregnant. |
| <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Grinding of Teeth | <input type="checkbox"/> Fatigue | Other: |

Please check any areas below that you would like improvement in.

- | | | |
|--|---|--|
| <input type="checkbox"/> Negative self-talk, self-sabotage | <input type="checkbox"/> Ability to reach ideal weight | <input type="checkbox"/> Increase learning ability |
| <input type="checkbox"/> Belief in ability to achieve goals | <input type="checkbox"/> Personal magnetism | <input type="checkbox"/> Beneficial, relationships |
| <input type="checkbox"/> Ability to relax | <input type="checkbox"/> Strengthen
memory/concentration | <input type="checkbox"/> Prosperity (attract what you
choose) |
| <input type="checkbox"/> Ability to use dreams as mental
tool for problem solving | <input type="checkbox"/> Breaking old habits | <input type="checkbox"/> Attitude and skills at work |
| <input type="checkbox"/> Eliminate procrastination | <input type="checkbox"/> Release negative events | <input type="checkbox"/> Self-Esteem |
| | <input type="checkbox"/> Ability to align body/mind
for self-healing | <input type="checkbox"/> Youthful Vitality |
| | <input type="checkbox"/> Ability to take action | |

Below, please describe what you would like to accomplish with these treatments.