Client Questionnaire Form

Contact Details

Title		First Name		Last Name	
Street Address					
Town/Suburb				State	
Post Code		Email Address			
Home Phone		Mobile Phone No.			

Personal Details

How did you find out about us?							
Your Age		Birth Date		Occupation			
Do you consume drugs or medication? (Describe)							
Cigarettes?	P/Day	Water intake?	Glasses P/Day	Filtered water? Y/N			
Coffee intake?	Cups P/Day	Alcohol intake?	Glasses P/Day	Fast food? Y/N			
Soy foods? Y/N		Artificial sweetner? Y/N					
Diet drinks? Y/N							
Number of teeth fillings?		White		Gold		Amalgam		Root Canal	

State of Health

Please rate the following out of 10...

General Health?	/10 (10 excellent)	Energy Level?	/10 (10 high energy)
Pain?	/10 (10 high pain)	Describe	
Stress?	/10 (10 high stress)	Describe	
Other major surgery, accidents, illness?			
Other therapy you have received?			

Please circle any words that reflect your CURRENT conditions:

Alcoholism	Anaemia	Appendicitis	Arthritis	Asthma
Bronchitis	Cancer	Crohns Disease	Colitis	Celiac
Chicken Pox	Diabetes	Diphtheria	Eczema	Emphysema
Endometriosis	Glandular Fever	Goitre	Heart Disease	Herpes
Influenza	Measles	Miscarriage	Multiple Sclerosis	Mumps
Pleurisy	Pneumonia	Polio	Rheumatic Fever	Shingles
Stroke	Tonsillitis	Tuberculosis	Chest Pain	Ulcers – Mouth
Eating Disorders	Ulcers – Duodenal	Whooping Cough	Inflammation	Chemotherapy
Depression	Digestive Disorders	Coughing or Phlegm	Itchy Skin or Rashes	Urinary Problems
Cold or Heat	Anxiety/Nervousness	Menstruation problems	Memory Loss	Tight Jaw
Hot flushes	Dryness of Skin	Osteoporosis	Leg Pain	Grinding Teeth
Constipation	Diarrhoea	Tight Neck	Back Ache	Poor Appetite
Sweet Cravings	Abdominal Pain	Fear of driving	Tiredness	Allergies
Insomnia	Water Retention	Tinnitus	Panic Attacks	Blurry Vision
Migraines	Dizziness	Pins and Needles	Leg Cramps	Irritable/Frustration
Headaches	Loss of Balance	Numbness	Stiffness	Nausea
High Blood Pressure	Low Blood Pressure	Breathing Problems	Tired When Waking	Mood Swings
Bloating	High Cholesterol	Gum disease	Hair Loss	Frequent Urination
Geopathic Stress	Disconnected	Abuse	Addiction	Stress

WE DO NOT DIAGNOSE CONDITIONS OR PRESCRIBE MEDICATIONS. SEEK THE ADVICE OF YOUR HEALTHCARE PROFESSIONAL.

Thoughts And Desires

What are your biggest fears? Describe	
Who has been the most negative influence in your life? Describe	
Who has been the most positive influence in your life? Describe	
What are your dreams? What do you want to achieve in your life?	
Please describe in detail how you want to feel?	
Do you believe in Law of Attraction (ie. you are the creator of your life) and do you apply the principles?	
Please describe the priority issues you would like addressed?	

I understand your services balance energy and that you do not prescribe medications or diagnose diseases. It is my own personal responsibility to accommodate whatever my body presents and consult my health care provider if symptoms persist. I give my permission for future contact regarding related information via mail, email, or phone.

Signed:_____ Date:_____

Confidentiality is important to us. Please be assured we will keep your personal information safe.