North Country Spiritual Pathways & Wellness LLC

Confidential Client Case History and Intake Form

Name:	**Date:**
Address:	**Phone:**
Postal Code:	**Email:**
Date of Birth:	**Referred by:**
Would you like to receive updates via email?	

In order to plan a session that is safe and effective, I need some general information about your health, medical and wellness history.

Primary Concerns:	Level: 1 (hardly notice symptoms) to 10 (symptoms are unbearable)

Significant Accidents/Injuries:

Place an X beside any symptoms that you experience:

Headache	Heavy feeling in limbs	Cold in hands and feet	Faintness/Dizziness
Blurriness of vision	Lower back pain	Tightness in jaw	Constipation
Shoulder/neck pain	Weak body parts	Loose bowel movements	Carpel Tunnel Syndrome
Smoking (#/day __)	Irritated bowel	Menstrual irregularities	Nervousness
Pains in heart/chest	Poor appetite	Indigestion	Excessive urination
Insomnia	Grinding teeth	Fatigue	Are you pregnant?

Other Medical Issues you feel I should be aware of:

_____

_____

_____

_____

By signing this, I affirm that I have stated all my known medical conditions and answered all questions honestly and to the best of my knowledge and that I will inform the practitioner of any changes in my condition(s) or medication(s). I understand that there shall be no liability on the practitioner's part should I fail to do so. By signing this I agree to the terms found in the Policies and Procedures.

_____ _____ _____

Client's Signature Print Name Date