CLIENT INTAKE FORM

Print this form and fill it before you visit Mala Jham for a healing session.

Name: Date:

Email : Occupation :

Address:

Height : Weight : Date of Birth :

Phone Home : Phone Work :

Emergency Contact (name & phone):

Relationship Status: # Children : Ages :

Referred by :

Physician (name & phone):

Therapist (name & phone) :

Reason for Visit (add details on back if necessary) :

Date of Onset :

Current/Previous Treatment (for reason for visit) :

Current Medications :

Current Complementary Therapies/Supplements :

Eating Habits/Diet :

Amount Daily Intake:
Water: Caffeine: Alcohol: Cigarette/Tobacco:

Exercise routine :

Vision:- Wear glasses/contacts Smell: Hearing: Taste:

Please mark the following areas of disease or symptoms as "C" – current, "P" - past, "O"– occasional and "CH" - chronic.Explain if necessary.

EMOTIONAL / PSYCHOLOGICAL		NEUROLOGICAL(type)		RESPIRATORY		REPRODUCTIVE	
Depression		Epilepsy		Bronchitis		Sexually Trans. Disease (type)	
Eating disorder		Dizziness		Pneumonia/Pleurisy			
Mood swings		Insomnia		Tuberculosis			
Substance abuse		Migraines		DIGESTION		Endometriosis	
AUTO-IMMUNE (type)		MUSCULO-SKELETAL		Constipation (chronic)		Pregnancies (# & C if current)	
AIDS/HIV		Arthritis		Diabetes		Miscarriages (#)	
Allergies		Rheumatism		Diarrhea (chronic)		Abortion (#)	
Cancer (type)		Back Pain		Gastritis		MAJOR ILLNESSES	
Fatigue		Carpal Tunnel		Hepatitis		Chicken Pox	
Fever (chronic)		Gout		Hypoglycemia		Measles	
Fibromyalgia		Skin Disorder (type)		Jaundice		German Measles	
Fungal Infections (type)		EAR/NOSE/THROAT		Liver Disorder		Mumps	
Herpes (type)		Earaches (chronic)		Ulcers		Whooping Cough	
Lyme Disease		Headaches		Flatulence		Rheumatic Fever	
Mononucleosis		Jaw Pain		Pancreas		Scarlet Fever	
ENDOCRINE		CARDIO-VASCULAR		URINARY		OTHERS	
Adrenal Insufficiency		Angina		Bladder Infection			
Pituitary Dysfunction		Heart Attack		Kidney Stones			
Hyperthyroid		Heart Failure					
Hypothyroid		Hypertension					
		Stroke					

- Please list any injuries you had and have:

- Please list any surgeries you have had or know you will have:

- Please list any traumatic, or life threatening events that occurred in your life, and when they happened: (ex. Separation, divorce, deaths, depressions or other significant event) :

- What do you hope for and what are your expectations from this healing today and long-term:

- Is there anything else you want to share or want me to know?
