

Confidential Client Information

Name: _____ Date: _____

Street: _____ Birth Date: _____

City, State, Zip: _____ Home Phone Number: _____

Occupation: _____ Cell Phone Number: _____

Work Phone Number: _____ E-mail: _____

Marital Status: Single Married Divorced Okay to leave message: Yes No

Widowed Are you over the age 18? Yes No

Purpose of Visit: (If you need additional space, please use other side) _____

List any health problems: _____

Are you currently taking any prescription drugs? Yes No

If yes, list medication and purpose: _____

Recreational drug usage: Yes No

If yes, please explain: _____

Alcohol consumption: Never Daily Weekly Occasionally

If weekly, please list average number: _____

Have you previously been hypnotized? Yes No

Do you meditate? Yes No

If yes, what technique and for what purpose? _____

Please list fears or phobias: (water, heights, etc.) _____

How were you referred here? Please list name:

I hereby agree to the use of Life Balancing techniques and acknowledge that these techniques present a potentially powerful mental and physical regulating tool. I understand that personal results will vary and that there are no expressed or implied guarantees or warranties of results. I am fully informed of the nature and usefulness of Life Balancing. Further, I am aware that this program is non-medical in nature and for any changes in medications I will consult my health practitioner.

Signature: _____ Date: _____