



WELCOME TO HOLISTIC CONNECTIONS

all things are possible through holistic connections

PATIENT INFORMATION FORM

TODAY'S DATE: _____

NAME: _____

DOB: _____

SEX: _____

ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

PHONE NUMBER: _____

CELL PHONE: _____

EMAIL : _____

IN CASE OF EMERGENCY CONTACT INFORMATION:

NAME: _____

PHONE NUMBER: _____

ARE YOU ON ANY MEDICATIONS, SUPPLEMENTS AND/OR VITAMINS? _____

IF YES, PLEASE LIST NAMES & MG TAKEN DAILY: _____

PLEASE LIST ANY PHYSICAL ISSUES YOU ARE EXPERIENCING (whether or not they relate to the current issue): _____

PLEASE EXPLAIN REASONS FOR APPOINTMENT: _____

HOW LONG HAVE YOU BEEN EXPERIENCING THIS ISSUE: _____

DO YOU KNOW THE SOURCE OR CAUSE OF ISSUE (yes or no): _____

IF SO, PLEASE EXPLAIN: _____

WHAT SYMPTOMS ARE YOU EXPERIENCING WITH THIS ISSUE: _____

IF EXPERIENCING PHYSICAL PAIN, ON A SCALE OF 1- 10, HOW WOULD YOU RATE YOUR PAIN? _____

IF EXPERIENCING EMOTIONAL UPSET, ON A SCALE OF 1-10 HOW WOULD YOU RATE YOUR EMOTIONAL INTENSITY? _____

HAVE YOU SOUGHT PROFESSIONAL ASSISTANCE WITH THIS ISSUE BEFORE? (yes or no) _____

IF YES, WHAT TYPE OF THERAPY HAVE YOU EXPERIENCED: _____

DID YOU FIND THIS OR THESE THERAPIES EFFECTIVE? (Please explain) _____

HAVE YOU EXPERIENCE ANY OTHER TYPES OF HOLISTIC HEALTH CARE: (yes or no) _____

IF YES, PLEASE LIST WHICH TYPES: (examples include: acuunctures, massage therapy, EMDR, NET, psychotherapy, ect.) _____

PLEASE EXPLAIN WHAT YOU WOULD LIKE TO ACHIEVE FROM THIS APPOINTMENT: _____

I GIVE MYSELF PERMISSION TO LET GO OF ANY PHYSICAL, MENTAL, EMOTIONAL ISSUE THAT KEEPS ME FROM LIVING THE LIFE THAT I DERSERVE.

SIGN HERE: _____

DATE: _____

PRACTITIONER'S NOTES: