BELOVED SPIRIT

LAURA DAVIDSON

734 476 9555

CLIENT INTAKE FORM

Name ____ Date of Visit ____________

Address ____

Date of Birth ____________________ Height________________ Weight ____________

Occupation _____________ Work Phone______________ Home Phone_______________

Relationship Status _______________Children ___________Referred By _____________

Therapist (name, address, phone) ____

Physician (name, address, phone) ____

Therapeutic/ Spiritual Growth Experience ____

Reason for Visit ____

____

Date of Onset ________________ Sudden _______ Slow _______

Previous Treatment ____

Antibiotics/ Medications Currently Taken ____

Non-Medicinal Drugs Currently Taken ____

Alcohol Intake_______Tobacco/ Cigarettes ______Daily Fluid Intake (Not Alcohol) ________

General Type of Diet ____

Exercise ____

Vision _______Wear Glasses /Contacts ______ Smell______ Hearing_______ Taste _____

Accidents/ Injuries ____

Surgeries ____

BELOVED SPIRIT

LAURA DAVIDSON

734 476 9555

Intake Form Continued

Do you have or have you had: (Please mark "C" to indicate current symptoms or "P" for symptoms you have had in the past.)

__Constipation	__Back Pain	__Fungal Infections	__Rheumatic Fever	__Syphilis
__Diarrhea	__Hypertension	__Bronchitis	__Fever	__Heart Disease
__Flatulence	__Depression	__Emphysema	__Malaria	__Cancer
__Indigestion	__Mood Swings	__Pleurisy	__Mononucleosis	__Epilepsy
__Gastritis	__Insomnia	__Pneumonia	__Tuberculosis	__Stroke
__Dysentery	__Fatigue	__Chicken Pox	__Rheumatism	__Female Organ Problems
__Dizziness	__Ulcers	__Measles	__Arthritis	__Pancreas Problems
__Migraines	__Allergies	__German Measles	__Diabetes	__Liver Problems
__Headaches	__Eczema	__Mumps	__Herpes Simplex 1	__Kidney Problems
__Earaches	__Psoriasis	__Whooping Cough	__Herpes Simplex II	__AIDS
__Jaw Pain	__Dandruff	__Jaundice	__Gonorrhea	__Hypoglycemia

What are your goals/ expectations from this healing today? Long range?

____

____

____

____

____

____

____

____

____

____

____

____

____