CLIENT INTAKE FORM

_____ _____ _____
First Name* Middle Initial Last Name*

_____
Street Address*

_____ _____ _____
City* State* Zip*

_____/_____/_____ _____
Date of Birth* Email Address*

- - - -
_____ _____ _____ _____ _____ _____
Phone Number* Landline for Phone Sessions

_____
Referred By

Describe your major health concerns*

_____

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_____

Do you experience physical pain or discomfort on a regular basis?_____Yes_____No

If yes, please list the area of pain, the severity on a scale of 1 to 10, 10 being most severe, and the frequency (number of times a day, week or month that pain usuallyoccurs).

Area of Pain	**Severity**	**Frequency**
Ex. Head, Neck, Right Knee	*On a scale of 1 to 10*	*# of times per day/week/month*

Do you experience being stressed out on a regular basis? ____ Yes ____ No

If yes, please indicate what your stress is about, the severity on a scale of 1 to 10, 10 being most severe, and the frequency (number of times a day, week or month that youexperience stress).

Stress About	**Severity**	**Frequency**
Ex. Relationship, Work	*On a scale of 1 to 10*	*# of times per day/week/month*

How many hours of sleep do you get on most nights? Provide any details about sleepissues that you experience. Ex. Waking up at night, Disturbed sleep, Nightmares etc.

_____

_____

DIVINITY HEALING CENTER

Describe your goals for wellness*

_____

_____

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Are you pregnant? _____ Yes_____No _____ Not sure, but possible

Do you have a pacemaker or any implanted device? _____ Yes _____ No

If yes, please explain. _____

Do you agree to the use of magnets in your session? _____ Yes _____ No

(If you are pregnant, have a pacemaker, any other implanted device, or are otherwise sensitive tomagnets, you can still get the full benefit of the session without the use of magnets.)

Do you agree to inform your practitioner if you become pregnant, get an implanted device, or change your preference regarding magnet use? _____ Yes _____ No

☐ I agree that Divinity Healing LLC or Divinity center does notprovide any medical advice, diagnosis or treatment. It is my responsibility to always consult a qualified healthcare provider before making any changes to my treatment protocol or medications that I am using. If I have any questions about a medical condition, I will seek the advice of my physician. I understand that sessionswith Divinity Center are not intended to be a substitute for professional medical advice, diagnosis or treatment.

PRINT NAME:_____DATE:_____/___/_____

SIGNATURE: _____