Wellness • Balance • Harmony

NEW CLIENT INFORMATION FORM

First Name: **Last Name**: **Age**:

Address: City: Postal Code:

Email:

Home Phone: Mobile:

Emergency Contact

Name: Phone:

Basic Health

What concerns, issues or problems brought you to the office today?

Are you experiencing any pain in your body? ☐ YES ☐ NO

If YES, where is the pain? ☐ Upper Body ☐ Lower Body ☐ Joints ☐ Other

Please describe:

Are you taking any medication for the pain? ☐ YES ☐ NO

How is your general health?

How many hours do you sleep per night? Do you wake rested? ☐ YES ☐ NO

What level of personal stress are you experiencing in your daily life right now?

☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

What are the main stressor(s) in your life?

☐ Financial ☐ Job related ☐ Marriage ☐ Health

☐ Interpersonal ☐ Unfulfilled ☐ Family ☐ Spiritual

What do you do to deal with stress?

Other

Have you had any history of seizures? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Is there anything else you'd like to add?

Note: Please download and save this form as your_ name.pdf. Complete the form and save it.
Next, submit the form via email to: jana@wellnessbalanceharmony.com