# Client Information and Questionnaire

Name:

Date of birth and current age:

Address:

Tel. No.: Email:

Occupation:

Referred by:

□ Married □ Separated □ Divorced □ Widowed □ Single

Number of children: and ages:

Please describe any concerns you have about your current family situation:

Please list any major childhood or adolescent traumas:

Medical history (i.e., chronic illnesses, any major surgery, accidents):

Are you currently under a physician’s care, and if so, for what?:

Are you currently seeing a psychiatrist or psychotherapist? :

Please list any prescription medications that you are currently on and what they are for:

Please list any foods or substances to which you know or suspect that you may be allergic

or sensitive to:

(Women) Are you either pregnant, or nursing?:

Do you have a pacemaker, or any implanted metal or devices? :

Do you exercise regularly? How often and for how long? :

How many hours of sleep do you get at night? :

Do you seem to catch colds easily and/or frequently? :

How many glasses of water a day do you drink? :

Do you smoke tobacco? :

Do you drink alcohol? : If so, how much and how often? :

Do you drink coffee? : If so, how often? :

Do you use artificial sweeteners or drink diet drinks? :

Do you take vitamins? If so please list them:

What do you do for self-care?:

Please list any alternative healing modalities you've used or experienced and any

remedies that you remember taking:

Do you feel that your daily demands exceed your coping resources and/or support system?:

*Please place an* ***X*** *by any of the following that describes or applies to you:*

I am often not able to express my emotions.

I am dissatisfied with my job.

I am often stressed out and not able to cope properly.

Even though I’m in a relationship, I often feel lonely.

I often feel anxious and nervous for no good reason.

I don’t sleep well at night and have a hard time waking up in the morning.

I often suffer from bad dreams and nightmares.

There are many things I’d like to change in my life I just don’t have the means.

I have very low energy and often feel exhausted mentally and physically.

I don’t enjoy my work and would rather be doing something else.

I find my children irritating and hard to relate to.

I have very few hobbies.

I don’t regularly take time for myself (downtime).

I often feel depressed for no reason.

I have a hard time letting go of the past.

I don’t look towards the future with much enthusiasm.

I am not able to concentrate for extended periods of time.

My outlook is more negative than positive.

I spend a great deal of time worrying about what people think about me.

**LIFE STRESSORS** – *Please place an X by any that apply to you*:

Childhood emotional abuse

Childhood physical abuse

Sexual abuse

Abortion/miscarriage

Exposure to substance abuse

Alcohol/drug use or abuse

Loss/change of job

Serious family illness

Death of a family member

Loss/change of home

Addition to the household

Newly married

Separated/divorced

Social problems

Problems at work

Work more than 40 hours per week

Smoking

Which of the above major life events have you experienced in the last 2 years?:

How would you describe your current emotional state?:

Describe any condition or situation, which you would like to change/healed with the help of alternative/energy medicine (main reason for visit):

How long have you suffered from or had this problem (conflict, ailment, disorder,

concern)?:

What was happening in your life during or just before you noticed the problem (conflict,

ailment, disorder, concern)?:

If there is anything else you would like to state, please type it here:

***PLEASE NOTE***,in the fairness of both client and practitioner:

I am always happy to answer questions over the phone, *however*, phone calls over 5 minutes are considered a phone consultation and will be charged as thus.

Any remedies, essences or supplements that need to be ordered ***MUST*** be paid for in advance. Cancelled orders cannot be refunded.

Skype and phone sessions are $100 per hour and payment is due prior to the time of your session. Cancelled appointments *must* be made at least 24 hours in advance unless there is an emergency. Missed or cancelled appointments less than 24 hours will be charged the ***full amount*** of the session time scheduled.

I, , choose to see Shoshana Michel for Holistic Health consultations. I understand that she is not a physician or a licensed medical practitioner and therefore does not diagnose or prescribe, but makes recommendations and suggestions. I understand and agree that any information I receive from her is not to be construed as directions, or prescriptions of any kind. Said information is not to be interpreted as a substitution for medical advice, opinions, or treatment from a qualified physician. It is also not intended as a substitute for regular medical care. I also understand that some of the modalities used may still be considered to be in the experimental stage and thus I must take complete responsibility for my use of it. I agree to take full responsibility as to whether I act on the recommendations and suggestions given and to hold Shoshana Michel harmless.

Signature (type): Date: