

Confidential Client Information Sheet

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NAME _____ TODAY'S DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Home#(_____) _____ Cell(_____) _____

Do you give permission to contact you and leave a message at the above phone numbers? ___Yes ___No

EMAIL _____ Do you want to be contacted via email? ___Yes ___No

OCCUPATION _____ Work#(_____) _____

BIRTHDATE _____ AGE _____ M _____ F _____

RELATIONSHIP STATUS _____ SPOUSE/PARTNER NAME _____

NAMES & AGES OF CHILDREN _____

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ___Yes ___No ___Maybe

IF YES, HOW MANY WEEKS PREGNANT ARE YOU? _____

REASON FOR COMING? _____

LIST SURGICAL OPERATIONS AND DATES, BROKEN BONES, ACCIDENTS, AND DATES,
HISTORY OF SERIOUS PHYSICAL OR PSYCHOLOGICAL ILLNESS.

HOW DO YOU HOPE TO BENEFIT FROM OUR WORK TOGETHER?

CURRENT OR PAST USE OF ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS?

___yes ___no Please list all current medications and doses _____

WHAT OTHER KINDS OF HEALING/THERAPY WORK ARE YOU RECEIVING?

HABITS: ALCOHOL USAGE _____ (How many drinks per week?)

DRUGS (which ones) _____

TOBACCO _____ EXERCISE (how often) _____

FOOD (Do you have concerns about your eating habits?) _____

OTHER _____ COMMENTS ON THE ABOVE _____

MY SUPPORT SYSTEM IS COMPRISED OF _____

IS THERE ANYTHING ELSE IMPORTANT YOU THINK I SHOULD KNOW?

IN CASE OF EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ PHONE _____

PRINT YOUR NAME _____ SIGNATURE _____