Healing Arts
CHIROPRACTIC
HEALTH & WELLNESS CENTER

Client Information (All information is completely confidential)

Name: _____ Date: _____
Home Phone #: _____ Cell Phone #: _____
Address: _____ City/Zip: _____

Date of Birth: _____ Marital Status: S M W D # Children: _____
Occupation: _____
Email Address: _____

Purpose of this session: _____
Fears/Phobias? Please List: _____

Ever been treated for: Diabetes – Epilepsy – Heart Disorder – Digestive Problems – Emotional Issues
Are you presently under a doctor's care? Yes No
Explain:_____I have your permission to contact your physician if it is appropriate. _____ (Initials)

Quality of life for today: Excellent Fine Just OK Not Good

Quality of life this past week: Excellent Fine Just OK Not Good

Do you generally sleep through the night? Excellent Fine Just OK Not Good

Do you generally waken feeling refreshed? Excellent Fine Just OK Not Good

Pain level today (1-10; 10 unbearable): 1 2 3 4 5 6 7 8 9 10

Pain during this past week: 1 2 3 4 5 6 7 8 9 10

For Smokers: # of cigarettes per day: _____ # packs per day: _____
How many years have you been smoking? _____

Referred by: _____
Emergency Contact: Name: _____Phone: _____

I understand that Hypnotherapy is not a substitute for medical or psychological diagnosis and treatment. I also understand that Hypnotherapists do not diagnose conditions, do not prescribe or perform medical or psychological treatment, and do not interfere with the treatment of licensed medical or psychological professionals. I am willing to participate in hypnosis for relaxation and for the purposes of self-improvement. It is recommended that I see a licensed physician or health care professional for any physical or psychological ailments I might have.

Signature: _____ Date: _____

TEL. 720.328.6494 | **EMAIL** drbrian@healingartschiroboulder.com
1660 30th St., Boulder, CO 80301 | **www.HealingArtsChiroBoulder.com**
Chiropractic Physician | Certified Acupuncturist | Hypnotherapist | Shamanic Practitioner