

Start Date: ___/___/20___

NameDOB .../.../.... Age.....Yrs
 Address.....
 City..... State P/Code.....
 Phone Mob: Email
 OccupationPlace of Work
 Marital Status.
 Children Names and ages

 Hobbies and Interests. What do you do in your time off?

 How did you hear about us?

HOW CAN WE HELP?

What are your Goals for our session today? Do you have anything in particular you'd like to work on?

Medical History

Have you ever been treated or for any psychological or emotional issues? Yes No
 If so what were you treated for? Anxiety Depression
 Stress..... Grief..... Addiction/Habits
 Other

What treatment were you given?

Dr.'s / Therapist's name and contact details


 How is your health I general?.....
 Have you ever been treated for? Heart Diabetes Epilepsy Pain Other
 Details.....

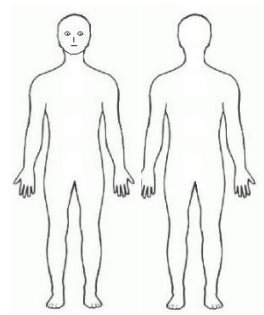
Have you had any prolonged illness? Yes No. Details.....

Are you currently taking any medications? Yes No
 If so, what, and the reason for the mediation

If you were referred by your Doctor or Counsellor, do I have your permission to contact them if necessary? Yes..... No

Current Physical Problems/Pain/Dis-ease in the Body

Please indicate any areas of concern on the body pictures to the right. 
 Current level of Pain/Discomfort? **0 1 2 3 4 5 6 7 8 9 10 ▲**
 Current level of Emotion or Stress? **0 1 2 3 4 5 6 7 8 9 10 ▲**
 History



I agree that all the information I have given is correct and agree to undertake this TFH Muscle Monitoring and Balancing Session.

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 Client Signature

*Parent/Guardian Signature (if under 18 years old)