



The Art of Healing
 1305 Shoshone Street
 Boise ID 83705
 (208) 850-1830



**Confidential Client Intake Form
 Side Two**

Are you aware of any belief systems that inhibit your healing/transformation/growth?

- _____
- _____
- _____

Do you ever experience challenging thoughts? (negative, chronic, fearful, circular, worry, past issues, disrupt sleep & etc...)

- _____
- _____
- _____

Please list any childhood/adult traumas, stressors, losses, & emotional challenges. (include aprox. date)

- _____
- _____
- _____

Please list any childhood/adult illnesses, surgeries, injuries & etc... (include aprox. date & length of time if still active)

- _____
- _____
- _____
- _____

Is there anything else that you would like to share with me about yourself?

- _____
- _____
- _____

Name of primary physician _____ Phone: _____

Are you currently suffering from any current health challenges of Mind, Body, Heart, Spirit?

- _____
- _____
- _____

List any prescription medications & over the counter products you are taking:

- _____
- _____
- _____

List any herbs, supplements, & etc.. you are taking:

- _____
- _____
- _____

Print Name: _____ **Signature:** _____ **Date:** _____

I give Pamela S. Robinson permission to work with the minor child _____

Print Name: _____ **Signature:** _____ **Date:** _____