HARMONY OF ENERGY

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CONFIDENTIAL

CLIENT CASED HISTORY

Name	Date
Address	
Date of birth	Mobile
Email	

3 PRIMARY CONCERNS	RATE YOUR SYMPTOMS
PHYSICAL ☐ EMOTIONAL ☐ BOTH ☐	1 - hardly notice 10 - unbearable
a)	
b)	
c)	

MEDICATIONS / REMEDIES / SUPPLEMENTS AND REASONS FOR TAKING

SIGNIFICANT ACCIDENTS / INJURIES

PLEASE TICK ANY CONDITION THAT APPLY (PAST OR PRESENT)		
Cancer	Varicose Veins	Allergies
Heart Disease	H / L Blood Pressure	Surgery
Diabetes	Paralysis	Genetic Disorders
Stroke	TMJ Dysfunction	Phobias
Epilepsy	Arthritis	Other

ADDITIONAL INFORMATION

PLEASE TICK BESIDE ANY SYMPTOM THAT YOU EXPERIENCE		
Headaches	Heavy Feeling In Limbs	Cold In Hands & Feet
Faintness / Dizziness	Weak Body Parts	Lower Back Pain
Tightness In Jaw	Blurriness Of Vision	Shoulder / Neck Pain
Pains In Heart / Chest	Constipation	Carpel Tunnel Syndrome
Nervousness	Loose Bowel Movements	Menstrual Irregularities
Poor Appetite	Irritated Bowel	Insomnia
Excessive Urination	Indigestion	Smoking - # / Day
Grinding On Teeth	Fatigue	Are You Pregnant?

PLEASE TICK BESIDE ANY AREAS BELOW THAT YOU WOULD LIKE IMPROVEMENT IN		
Negative self talk	Ability to reach ideal weight	Ability to take action
Self sabotage	Ability to break a bad habit	Increase learning ability
Belief in ability to achieve goals	Personal magnetism goal	Beneficial relationships
Ability to relax	Memory / concentration	Attract what is good for you
Mental tool for problem solving	Release negative events	Self-esteem
Eliminate procrastination	Ability to align self healing	Youthful vitality