BG"G

Eden Health & Mental Wellness

Client Intake Form

PERSONAL INFORMATION

Birth Name: Preferred Name (if different from Birth):

Age: Date of Birth:

Gender Identity: Sexual Orientation:

Employer: Occupation:

Faith/Religion:

MEDICAL INFORMATION

Doctor's Name & Phone Number: Date of Last Check-up:

Medications:

Medical & Psychiatric Hx:

FROM THE LIST BELOW CIRCLE/CHECK THE AREAS THAT CONCERN YOU

Addictions:
- Drinking
- Drugs
- Food
- Gambling
- Sex
- Smoking

Mood/Behavior Disorders:
- Anxiety
- Compulsive Behavior
- Depression
- Fears/Phobias
- Panic Attacks
- Stress

Personal Goals:
- Career
- Childhood Problems
- Concentration
- Confidence
- Exams
- Guilt
- Memory
- Motivation
- Public Speaking
- Relationships
- Relaxation
- Self-Esteem
- Self-Hypnosis
- Speed Reading
- Performance

Health Concerns:
- Digestion
- Eating Disorders
- Fertility
- Nerves
- Pain Control
- Physical Impairments
- Respiratory Concerns
- Sexual Problems
- Skin Problems
- Sleep Problems
- Weight Problems
- Pain

Life Experiences:
- Trauma
- Grieving
- Loss

Circle Method of Payment: cash check w/ID credit card w/ID debit card w/ID

Debit/Credit Card #:_____ Exp.:_____ CVV#:_____

I, the above-named client, affirm all the aforementioned information is true and valid and, when applicable, I authorize payment in the form specified above and in the agreed-upon amount.

Signature_____ Date_____