Heart Flowers Healing Center
Client Questionnaire

In order to maximize the effectiveness and safety of our sessions together, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Your feedback is appreciated during and at the end of our sessions to help me in tailoring our sessions to serve in the best possible way.

Name _____ Date of Initial Visit _____
Address _____ City _____ State/Zip_____
Phone (day) _____ (eve) _____ Email _____
Occupation(s) _____ Referred by _____
Interest(s) _____ Date of Birth _____
What is your Goal or Concern for today's session? _____
_____
What is your previous experience with this type of work? _____
Do you experience any difficulty lying either on your belly or back? _____
Is there any area where you would like extra time spent, any area where you seem to hold a lot of tension?
_____
_____
Habits: Exercise _____
Tobacco _____ Alcohol _____
Drugs (non-med.) _____
Posture assumed most of the day _____
Sleep _____Digestion _____ Caffeine _____

Medical History:

____ Hypertension
____ Heart Disease
____ Arteriosclerosis
____ Varicose Veins
____ Skin Rash
____ Epilepsy
____ Allergies
____ Diabetes
____ HIV/AIDS
____ PMS/Painful Menstruation
____ Easy Bruising
____ Rheumatoid Arthritis
____ Abscess/Open Sore
____ Phlebitis
____ Skin Sensitivity
____ Inner Ear Problem
____ Cancer/Malignancy
____ Mental Illness
____ Osteoporosis
____ Osteoarthritis
____ Fibrositis
____ Herniated Disc
____ Headaches
____ Pregnancy(s)
____ Herpes I or II

____ Surgery/Fractures (explain) _____

_____

____ Musculoskeletal Pain/Stiffness (such as low back, neck, shoulder, etc) (Explain) _____

_____

_____

____ Any other physical or emotional difficulties? (Explain) _____

_____

_____

Do you wear Contacts? _____ Dentures? _____ Hearing Aids? _____

Are you under medical care or supervision now? _____ If so, for what condition? _____

_____

_____

Are you currently taking any medication? _____ If so, what? _____

_____

_____

Are there specific aspects of your life that are particularly stressful? (job, posture, habits, diet, family, etc.)? (Explain) _____

_____

_____

Do I have your permission to contact your doctor should the need arise? _____

Name of Doctor _____ Phone _____

Comments/Explanations:

My office policy is that you must give me 24 hour notice to cancel an appointment except in the case of a true emergency. Otherwise you must pay the full amount of the missed appointment.

Signature _____ ____Date _____

Witness _____