natural pain solutions
"relieving pain by creating wellness"

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New Client Form – Initial Consultation

Name: Date:

Main Complaints:

1) 2)

3) 4)

How long have you suffered with these problems?

Please list any other complaints:

Would you like improvement with any of the following?

- ☐ Digestion: Reflux, Gas, Constipation
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of Well Being
- ☐ Energy

What have you tried doing to resolve this problem that Did Not work?

Have you become discouraged or stressed about handling this problem?

When your problem is at its worst, how does it make you feel?

How does this problem interfere with the following areas in your life?

Work:

Family:

Hobbies:

Life:

When it's at its worst, how much older does this make you feel?

Do you know how this problem may have started?

What effect does this have on your body functions?

Are you here visiting us to:

- ☐ Resolve my immediate problem
- ☐ Life style program for optimized living
- ☐ Both
- ☐ Other:

How have you taken care of your health in the past?

- ☐ Medications
- ☐ Exercise
- ☐ Holistic
- ☐ Acupuncture/PT/Chiro
- ☐ Routine medical
- ☐ Diet and Nutrition
- ☐ Vitamins
- ☐ Other:

How did the previous methods work for you

What are you afraid this might be or will be affecting without change? **Please check all that apply:**

- ☐ Job
- ☐ Marriage
- ☐ Freedom
- ☐ Finances
- ☐ Kids
- ☐ Sleep
- ☐ Future abilities
- ☐ Time

Are there any health conditions you are afraid this might turn into?

- ☐ Diminish Future abilities
- ☐ Stress
- ☐ Weight gain
- ☐ Heart disease
- ☐ Depression
- ☐ Surgery
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other:

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific.

What would be different or better without this problem? **Please check all that apply:**

- ☐ Diminished Stress
- ☐ More Energy
- ☐ Self-Esteem
- ☐ Confidence
- ☐ Sleep Work
- ☐ Outlook on Life Family

If we were to sit down and discuss your life <u>3 years</u> from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and do not sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list).

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

- How important is it for you to resolve your health concerns?
- Do you feel that you are coachable and would enjoy a mentor in helping you?
- Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

THANK YOU!