HARMONIC EGG BUFFALO
RESONATE • RELAX • RENEW

Confidential Client Intake

Client:_____ DOB:_____ Height:_____ Weight:_____
Phone: Cell:_____ Other:_____
Address: _____ Email: _____
City:_____ State: _____Zip Code: _____
Emergency Contact: _____ Relation:_____ Phone:_____
Relationship Status: Single Married Partner Separated Divorced Widow Widower
Spouse/Partner Name: _____# of Children: _____
Occupation: _____ Do you enjoy your job? Y N
Primary Reason for your visit: _____
Have others helped you with the problem: _____
What are your expectations after the sessions: _____
Who can we **thank** for your being here (who referred you): _____
Check conditions listed below which you have experienced: Use **P** (past) **C** (current)

METABOLISM
___Weight Gain
___Weight Loss
___High/Low BP
___Blood Sugar
___Thyroid

SKIN
___Rash
___Dry Skin
___Acne
___Eczema
___Botox.
___Injectables

EYES/EARS/MOUTH
___Headaches
___Dizziness
___Ringing in Ears
___Blurred Vision
___Sinus Problems
___Difficulty Swallowing
___Mouth Sores

DENTAL
___Tooth Problems
___Root Canals
___Amalgam Fillings
___Difficulty Chewing
___TMJ

CHEST
___Chest Pain
___Palpitations
___Cough
___Shortness of Breath
___Asthma

NEUROLOGIC
___Numbness or Tingling
___Weakness
___Insomnia
___Poor Balance

MALE
___Prostate
___Cancer

DIGESTION
___Heartburn
___Abdominal Pain
___Gas/Bloating
___Diarrhea
___Constipation
___Blood in Stool
___Ulcers
___Colitis
___Liver Disease

URINARY
___Frequent Urination
___Difficult Urination
___Incontinence

ALLERGIES
___Medications
___Chemicals
___Foods
___Plants

FEMALE
___Pregnant
___Problems w/periods
___Cancer
___Breast Tenderness
___Breast Implants
___Menopausal Symptoms

STRUCTURAL
___Arthritis
___Bursitis
___Osteoporosis
___Foot/AnkleSwelling
___Blood Clots/Phlebitis
___Varicose Veins
___Recent Surgery
___NeckPain/Problems
___Back Pain/Problems
___Sciatica

IMMUNE
___Chronic Fatigue
___Fibromyalgia
___Yeast Infections
___Viral Infections
___Strep or Mono
___Epstein-Barr
___Lyme

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Medications, Herbs, Supplements (list name, dose and purpose)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

We recommend drinking 90-128 ounces of water daily starting on the day before your first session and for the days of integration.
Do you expect any difficulty with this? Y N
Explain: _____
How often do you use the following? Alcohol _____ Tobacco_____
Coffee/Tea/Soda_____ Drugs/Cannabis _____

Injuries/Accidents? Y N Explain: _____
Traumatic life events leading to any illness: _____
_____
Toxic Exposure: _____
Describe other medical conditions that to be aware of: _____
___Cancer ___Heart Problems ___Stroke ___Seizures ___Diabetes ___MS
Other: _____
Areas in body of complaint or tension:_____
Surgeries: (list any metal plates/rods/screws) _____
_____
Family Medical History: ___Diabetes ___Heart Problems ___High BP ___Cancer ___Alzheimer's
Other: _____

Current Pain Level (1=very low, 5=very high) 1 2 3 4 5 Explain: _____

Current Stress Level (1= very low, 5=very high) 1 2 3 4 5 Explain: _____

Current Energy Level (1= very low, 5=very high) 1 2 3 4 5 Explain: _____