

## Client Intake Questionnaire

### Personal Details

<b>Name:</b>	<b>Relationship Status:</b>
<b>Address:</b>	<b>Children:</b>
	<b>Physician:</b>
	<b>Tel:</b>
<b>Postcode:</b>	
	<b>Therapist:</b>
<b>Date of birth:</b>	<b>Tel:</b>
<b>Contact Tel:</b>	<b>Emergency Contact:</b>
<b>Occupation:</b>	<b>Tel:</b>

**Before treatment begins it is essential that you disclose your state of health.  
Please be as thorough as possible in answering the questions below.  
All information remains strictly confidential.**

**Reason for visit:**

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**List current health issues (including pregnancy), current medications (including vitamins, supplements, etc), treatments/therapies:**

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**List historical illnesses, accidents, hospitalisations, investigations, treatments and medications. Include childhood diseases, births and any long term prescriptions (i.e., contraceptives, HRT, tranquillisers, blood pressure, etc.):**

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**List significant health related issues of blood relations if known:**

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**Describe the main stresses in your life:**

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**Please describe your childhood (include details of any trauma of which you are aware):**

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**Indicate quantity and frequencies for the items below:**

Diet: -----  
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Alcohol: ----- Tea/Coffee: -----  
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Tobacco/Cigarettes: ----- Recreational drugs: -----  
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Daily fluid intake: ----- Exercise: -----  
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**Please provide any other information that you believe might be useful.**

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**I understand that Stephen Crook is not a licenced health professional and does not diagnose. I understand that the treatment provided is not a substitute for medical examinations, diagnoses and/or treatment and that it is my responsibility to consult a licenced health professional for any ailment that affects my health. I have disclosed all conditions pertaining to my health on this form and take responsibility for disclosing future health related issues.**

**Cancellation Policy: I understand that at least 24 hours notice is required when cancelling an appointment. I agree to pay the full treatment fee for either a late cancellation or a missed appointment.**

**Late Arrival Policy: I understand that my treatment time will end at the scheduled time. Should I arrive late, I agree to pay the full fee.**

**Payment Policy: I agree to pay by cash or cheque after my treatment unless other payment arrangements have been agreed in advance. I agree to pay any additional fees incurred if my cheque is returned by the bank.**

**I am aware that the therapy offered involves a therapeutic form of touch. As such, I understand that therapeutic touch is strictly non-sexual and that any illicit or sexually suggestive remarks or advances will result in the immediate termination of the treatment, and I will be liable for full payment of the scheduled appointment.**

**I have carefully read and understand all of the above and I have answered all of the questions fully, accurately and to the best of my ability.**

**Client Signature: ----- Date: -----**