



Health And Well Being

Name:

Email:

Address:

City, State, Zip:

Phone:

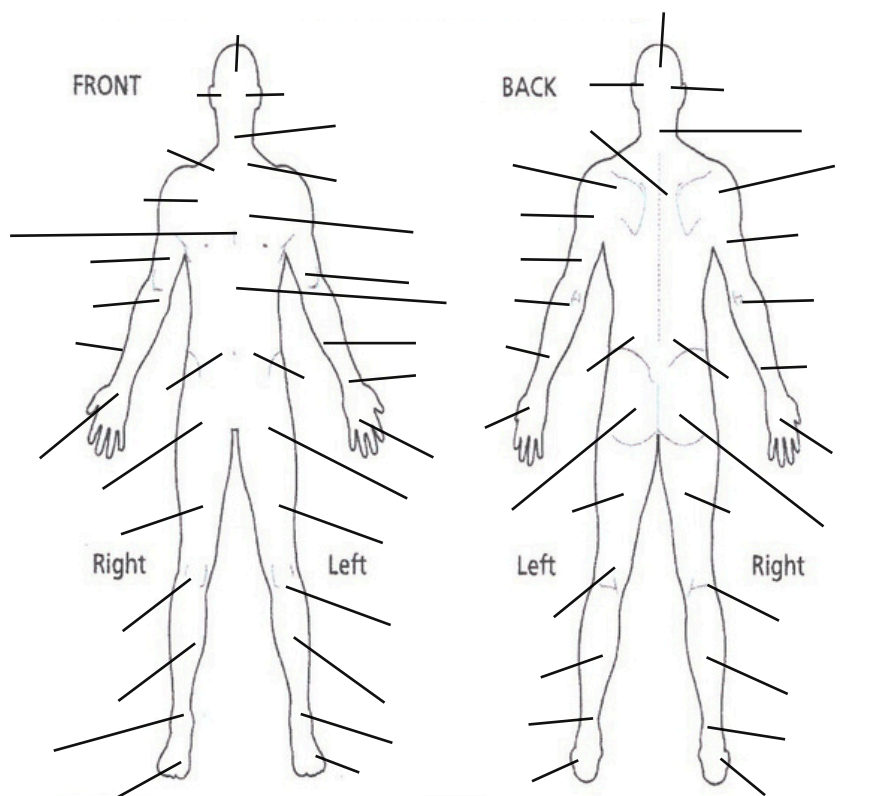
Reason For Visit

(Physical, Emotional, Mental, Life Circumstances)

Mark the emotions you are currently feeling or have felt in the past few months

Angry	Sad	Rejected	Impatient
Nervous	Resentment	Worried	Grief
Helpless	Uneasy	Fearful	Hopeless
Paralyzed	Frustrated	Annoyed	Despair
Depressed	Uncertain	Persecuted	Anxious
Agitated	Guilty	Criticized	Intimidated
Panicked	Overwhelmed	Abused	Hate
Overworked	Anguished	Muddled	Regret

Please mark areas of pain or discomfort on the body diagrams and make comments on the side if necessary.



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Comments

Print Name

Medical Condition

List current conditions, previous injuries, accidents, surgeries etc. Please include approximate dates

I understand that Your First Light Sessions are complementary integrative conscious-based mind/body non-invasive approaches to health and healing that assists my body in its natural ability to heal. Certified practitioners do not diagnose illness or disease, or prescribe medications. I am encouraged to seek medical care. All client records and experiences are confidential. I give my consent for such treatments.

Signature _____

Date _____

Signature (type name or use Fill & Sign tool)