



Health And Well Being Form

Name: _____ Email: _____

Address: _____ City, State, Zip: _____

Phone: _____

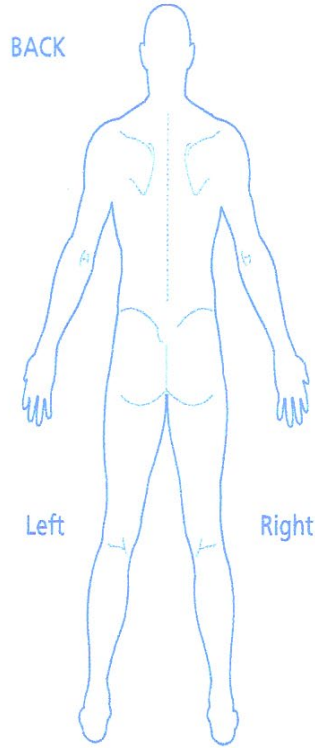
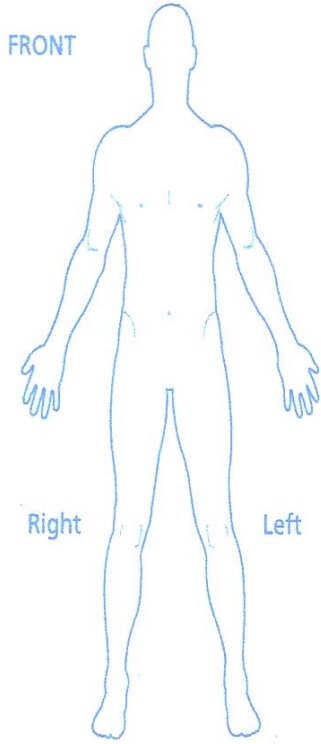
Reason For Visit

(Physical, Emotional, Mental, Life Circumstances)

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



COMMENTS:

Client signature:

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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 _____