



**Gail Lois Jaffe, P. A.**  
**Healer -- Artist**

**CLIENT INTAKE FORM**  
 (CONFIDENTIAL – for Practitioner’s use only)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Emergency Contact (name & phone): \_\_\_\_\_  
 Relationship Status: \_\_\_\_\_ No. Children: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Physician (name & phone): \_\_\_\_\_  
 Therapist (name & phone): \_\_\_\_\_  
 Reason for Visit: \_\_\_\_\_  
 \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 Current/Previous Treatment (for above): \_\_\_\_\_  
 Current Medications: \_\_\_\_\_  
 Current Complementary Therapies/Supplements: \_\_\_\_\_  
 Eating Habits/Diet: \_\_\_\_\_  
 Amount Daily Intake: Water \_\_\_\_\_ Caffeine \_\_\_\_\_ Alcohol \_\_\_\_\_ Cigarette/Tobacco \_\_\_\_\_  
 Exercise Routine: \_\_\_\_\_

*Please mark the following areas of diseases or symptoms as “C” for current, “P” for past, “CH for chronic. Explain if necessary.*

EMOTIONAL/PSYCH.	Hyperthyroid	Heart Attack	URINARY
Depression	Hypothyroid	Heart Failure	Bladder Infection
Eating Disorder	NEUROLOGICAL	Hypertension	Kidney Stones
Mood Swings	Epilepsy	Stroke	REPRODUCTIVE
Substance Abuse (type)	Dizziness	RESPIRATORY	Sex. Trans. Dis. (type)
AUTO-IMMUNE	Insomnia	Bronchitis	Endometriosis
AIDS/HIV	Migraines	Emphysema	Pregnancies (# & “C” if current)
Allergies	MUSCULO-SKELETAL	Pneumonia	Miscarriage (#)
Cancer (type)	Arthritis	Tuberculosis	Abortion (#)
Fatigue	Back Pain	DIGESTION	
Fever (chronic)	Carpal Tunnel	Constipation (chronic)	OTHER:
Fibromyalgia	Gout	Diabetes	
Fungal Infections (type)	Skin Disorder (type)	Diarrhea (chronic)	
Herpes (type)	E N T	Gastritis	
Lyme Disease	Ear aches (chronic)	Hepatitis	
Mononucleosis	Headaches	Hypoglycemia	
ENDOCRINE	Jaw Pain	Jaundice	
Adrenal Insuf.	CARDIOVASCULAR	Liver Disorder	
Pituitary Dysf.	Angina	Ulcers	



Gail Lois Jaffe, P. A.  
Healer -- Artist

CLIENT INTAKE FORM  
(CONFIDENTIAL – for Practitioner’s use only)

Please list any injuries you’ve had and/or have:

---

---

---

---

---

---

Please list any surgeries you had or know you will be having:

---

---

---

---

---

---

Please list any traumatic or life threatening events that occurred in your life and when they happened:

---

---

---

---

---

---

What do you hope for and what are your expectations from this healing today and long-term?

---

---

---

---

---

---

Is there anything else you want to share or want me to know?

---

---

---

---

---

---