

**CLIENT INTAKE FORM**  
**Peggy Reynolds-Olsen HHP RCST**

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Sex \_\_\_\_\_

Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_

Place of Birth \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Referred By \_\_\_\_\_

Spouse's date of Birth \_\_\_\_\_

Number of Children/Sex and Ages \_\_\_\_\_

Have you ever had Counseling \_\_\_\_\_

Are you on any medications? \_\_\_\_\_

List all medications \_\_\_\_\_

Are you currently under the care of any health care professional? \_\_\_\_\_

Explain \_\_\_\_\_

Do you frequently suffer from stress? \_\_\_\_\_

Explain the source of your stress \_\_\_\_\_

Do you experience frequent headaches? \_\_\_\_\_

Have you ever been in any accidents? \_\_\_\_\_

Explain briefly the accidents Include dates

\_\_\_\_\_  
(You may use the page at the end of this form if you need more space)  
Briefly detail any traumatic occurrences in your life i.e.: deaths, accidents  
Divorce, war, attack. \_

Any Falls? Include dates

\_\_\_\_\_

Any Surgeries? Include dates

---

Please use the following page to explain in detail you feel you need to.

Please tell me anything you know about your birth, were you born in a hospital or at home? Was it Vaginal? Was your mother under anesthesia? Did you spend time in an incubator? Were you breast fed?

Are there any other conditions that I should be aware of?  
Explain

---

What is your Intention for coming to see me?

---

What brings you the greatest joy in your life?

**Cancellation policy:**  
Please give 24 hours notice or you will be charged for your visit.