



The Light Point Healing Center
Peggy A. McFarland, MS
P.O. Box 26, Hines, OR 97738
541-573-8000
www.thelightpoint.org

CLIENT INTAKE FORM

Client Name _____ Date _____

Client Information

Address _____

Phone (Home) _____
Work _____ Cell _____
Email _____
Okay to contact at work? _____
At home? _____ By email? _____
Date of birth _____
Employer _____
Occupation _____
Marital Status _____
(divorced, single, separated, never married, married, widowed)
Spouse/Partner Name _____
Names & Ages of Children _____

Emergency Contact _____
Contact Phone(s) _____

Primary Health Care Provider

Name _____
Address _____

Phone _____ FAX _____
Date of last exam _____

Current Health Information

List mental health and physical symptoms that are of most concern at this time.

Have you been treated for these concerns previously? When? By Whom? Was treatment successful? When did symptoms reoccur?

Health History

List & include dates & treatment. Write on back if necessary.
Surgeries

Accidents

Major Illnesses

Trauma

Any other significant events you wish to share?

Family Health History

Please give age, lists of illness, or if deceased (list cause of death and age of death.)

Mother:

Father:

Brothers & Sisters:

Maternal Grandparents:

Paternal Grandparents:

Lifestyle Factors

Habits (Please indicate if use is current or past, how much you use, and how often)

Tobacco _____

Alcohol _____

Drugs _____

Coffee/Caffeine Drinks _____

Sugar/Candy _____

Food Binging and/or Purging _____

Nutrients/Herbs/Supplements

Supplements	Form	Dosage	Frequency
<i>Eg. Vit C</i>	<i>Tablet</i>	<i>500mg</i>	<i>2/day</i>

Medications

Name	Form	Dosage	Frequency

List additional medications on back if necessary. Please include over the counter drugs.

Exercise Activities

Type	Never	Minutes	Hours	Weekly	Daily
Swim					
Run					
Walk					
Dance					
Bike					
Garden					
Golf					
Ski					
Curves					
Weights					
Yoga					
Other					
Other					
Other					

List daily activities affected by your condition. Please be specific.

Work

Home & Family

Social/Recreational

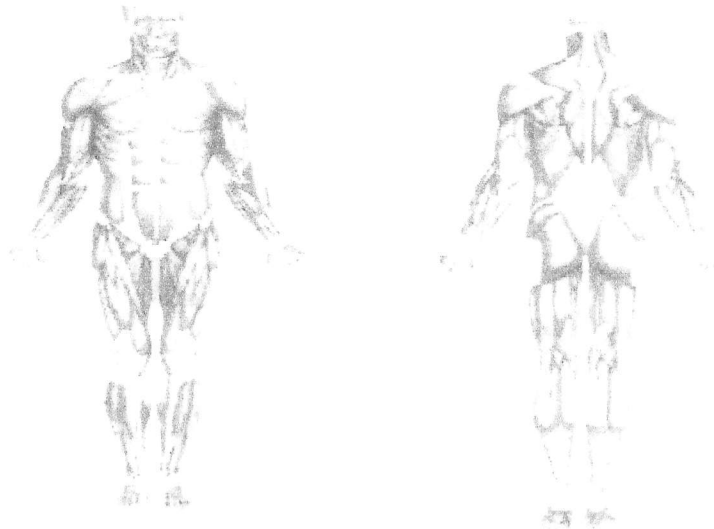
How do you reduce stress?

What are your goals for receiving therapy?



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Mark areas of pain/discomfort:



List any other issues you would like to have addressed during your session(s):

Rate your stress level as of today

