Juliana's Bach Flower Essences Services

(within)
Perfect Balance
Wellness Centre
125 Bedford Road • Kitchener, ON N2G 3A3

CLIENT INFORMATION & HEALTH HISTORY

Client Information (please print clearly)

Name: _____ Date of Birth: (mm/dd/yyyy) _____/_____/_____

Age: _____ Gender: _____ Marital status: _____

Do you have children? If yes, how many and how old _____

Address: _____ City: _____Postal Code: _____

Phone: (H) _____ (B) _____ (M) _____

Email: _____

Occupation: _____ Who referred you? _____

Approximate Weight: _____ Approximate Height: _____

What other practitioner are you currently seeing:

☐ Naturopath ☐ Osteopath ☐ RMT ☐ Chiropractor ☐ Homeopath ☐ Other: _____

Health History

What is your biggest/main problem/concern that you are most present to on a daily basis?

_____

_____

_____

_____

Have you been diagnosed with any health conditions? Any surgeries? _____

_____

Current Medications & Supplements (conditions they target): _____

_____

Have you been in a motor vehicle accident? ☐ Yes ☐ No If yes, when? _____

Any other accident(s)? _____

Have you experienced any major trauma (physical or emotional) in the last 5 years? If yes, please explain: _____

_____

How would you rate your current stress levels?

☐ Extremely stressed ☐ Very stressed ☐ Somewhat stressed ☐ Not stressed

What are the major causes of your stress, if any:

☐ Finances ☐ Family ☐ Career ☐ Spouse ☐ Health ☐ Other: _____

Do you have any coping mechanisms for stress? _____

Do you eat more or less when stressed? _____

Are you fulfilled with your occupation? _____

How would you rate your energy levels?

☐ Lots of energy ☐ Average ☐ Low energy ☐ No energy

On an average day, how many hours do you spend:

Driving _____ Watching TV _____ Reading _____ Online _____ Fun activities _____

Do you vacation regularly? If so, where do you travel to? _____

Is there anything else you wish to share? _____

_____

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Client Consent Form

Please print and sign after reviewing it thoroughly

I, realize that a Bach Flower Essences practitioner is not a medical doctor and cannot prescribe, diagnose or treat any specific diseases. The various strategies offered are designed to relieve stress, promote well-being and emotional wellness. I, the undersigned, being of sound mind and exercising my freedom of choice, do willingly desire the holistic therapies offered, in keeping with the Health Care Consent Act (1996). I understand that an assessment is required to determine the best strategies to help me meet my goals. I am aware that all information provided is private and confidential and will not be released without a written consent. I agree to communicate with my practitioner should I have any questions or concerns. I understand and I am aware of the posted fees and cancellation policy. I am also aware the clinic is not responsible for any lost, stolen or damaged articles.

_____ _____

Client Name (please print) Current Address

_____ _____

Client Signature Date

CANCELLATION POLICY – we require 24 hours notice if you are unable to make your scheduled appointment. After one initial warning, all subsequent missed appointments will be billed at the regular fee.

Do you wish to subscribe to Naturally Joyous' newsletter? ☐ Yes please! ☐ No, thank you!