



Client Information Form

DATE _____ FIRST NAME _____ LAST NAME _____

PARENT/LEGAL GUARDIAN FIRST NAME _____ LAST NAME _____

TELEPHONE # _____ May we call you at this # Y N May we leave a message at this # Y N

May we text you at this # Y N EMAIL ADDRESS _____

GENDER Female [] Male [] Other [] DOB _____ AGE _____ ETHNICITY _____

MARITAL STATUS Married [] Widowed [] Separated [] Single [] Divorced []

EMERGENCY CONTACT NAME _____ TELEPHONE # _____

RELATIONSHIP _____

PHYSICAL AILMENTS _____

CURRENT MENTAL HEALTH CHALLENGES

Anxiety _____ Depression _____ Lonliness _____ Sadness _____ Anger _____ Resentment _____ Fear/Worry _____ Mood Swings _____ Other _____ Please describe below

MEDICAL or MENTAL HEALTH DIAGNOSIS _____

Do you drink, smoke or use recreational drugs on a regular basis? _____

Do you use prescription medication in a manner other than perscribed? _____

What would be your ideal out come of connecting with HUGS approved healers? _____

Please describe anything else that you would like to share _____

REFERRED BY _____

Please return completed form by email to: info@elfempowers.org