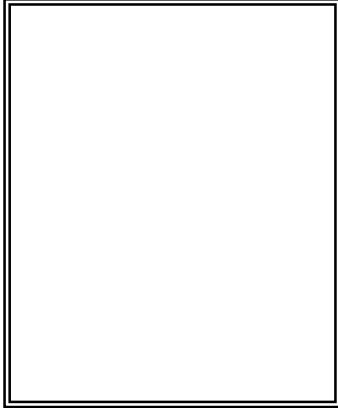


Institute of Complementary Therapies

Private Session Client Information

PLEASE PRINT CLEARLY (OR TYPE)



REQUIRED: PHOTO

Name _____

Address _____

Home Telephone: _____

Work Telephone: _____

Mobile Telephone: _____

Email address: _____

How did you hear about the ICT? _____

Circle and/Or Fill In - If any answers need more space please attach as necessary

Age	Date of Birth	Place of Birth	Time of Birth
-----	---------------	----------------	---------------

Gender: Female Male

Number of Siblings: 0 1 2 3 4 more _____

Marital Status: Single Married Divorced Widowed

Children: 0 1 2 3 4 more _____

Gender and Age of Siblings

Profession:

Formal Education Completed: AA BA MA PhD

Other Training

Hospitalizations, Surgery: (For physical or psychological reasons):

Birth History and Childhood (any know details and relevant history - e.g. mother received anesthetics, home or hospital, etc.):

Current Therapy: (current therapeutic modalities you are experiencing as a client/patient):

Past Experience of Therapies (modalities you have experienced as a client/patient):

Past Criminal Record (any criminal convictions):

Personal Time Line of Relevant Information (move/relocation, job change, etc.):
