PO Box 46, Sedona AZ, 86339

Client Intake Form

Name	
Address	
City	
State	
Zip Code	
Phone	
E-mail	
Age	
Occupation	

How did you hear about Kimberly Miles Communications?

Reason for requesting our services?

What previous efforts have you taken to resolve your situation and what were the results?

Are you currently under care, or undergoing medical or holistic treatment for this or any other condition?

Yes ☐ No ☐

Have you ever had or are you currently being treated for any of the following? (check all that apply)

Diabetes	☐	Arthritis	☐	Overweight	☐	Nervous Breakdown	☐
Epilepsy	☐	Migraines	☐	Underweight	☐	Depression	☐
Heart Condition	☐	Asthma	☐	Smoking	☐	High Blood Pressure	☐
Thyroid	☐	Allergies	☐	Drug Addiction	☐	Digestive Problems	☐
Ulcers	☐	Cancer	☐	Phobias	☐	Adrenal Fatigue	☐
Fibromyalgia	☐	Chronic Fatigue	☐	Alcoholism	☐	Other	☐

If Other, please elaborate.

Do you practice any form of relaxation or meditation techniques? Yes ☐ No ☐

If "yes", please explain method and how long.

Do you frequently wake up during the night)? Yes ☐ No ☐

Do you grind or clench your teeth? Yes ☐ No ☐

Do you have dental work: root canal, fillings, wisdom teeth removed? Yes ☐ No ☐

Do you take time for self-improvement? Yes ☐ No ☐

List examples

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Do you have fears or phobias? Yes ☐ No ☐

If "yes", please explain

Do you have issues with any of the following? If yes, check the box that applies to you.

	(1=mild, 2=moderate, 3=severe.)		
Parents	1 ☐	2 ☐	3 ☐
Being single	1 ☐	2 ☐	3 ☐
Marriage	1 ☐	2 ☐	3 ☐
Children	1 ☐	2 ☐	3 ☐
In-Laws	1 ☐	2 ☐	3 ☐
Divorce/Separation	1 ☐	2 ☐	3 ☐
Child Custody	1 ☐	2 ☐	3 ☐
Loneliness	1 ☐	2 ☐	3 ☐
Anger Control	1 ☐	2 ☐	3 ☐
Mood Swings	1 ☐	2 ☐	3 ☐
Fear/Anxiety	1 ☐	2 ☐	3 ☐
Communication	1 ☐	2 ☐	3 ☐
Procrastination	1 ☐	2 ☐	3 ☐
Self-Esteem	1 ☐	2 ☐	3 ☐
Confidence	1 ☐	2 ☐	3 ☐
Past Hurts	1 ☐	2 ☐	3 ☐
Grief/Loss	1 ☐	2 ☐	3 ☐
Depression	1 ☐	2 ☐	3 ☐
Stress Management	1 ☐	2 ☐	3 ☐
God/Faith	1 ☐	2 ☐	3 ☐
Co-dependency	1 ☐	2 ☐	3 ☐
Letting go	1 ☐	2 ☐	3 ☐
Aging/dependency	1 ☐	2 ☐	3 ☐
Disabled	1 ☐	2 ☐	3 ☐
Work/career	1 ☐	2 ☐	3 ☐
School/learning	1 ☐	2 ☐	3 ☐
Money/budgeting	1 ☐	2 ☐	3 ☐
Weight control	1 ☐	2 ☐	3 ☐
Alcohol/drugs	1 ☐	2 ☐	3 ☐

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Do you have any behavior patterns that you wish to change? Yes ☐ No ☐

If "yes" please explain.

What do you expect from these sessions?

You have the right to explore options and to educate yourself about your body and mind and how to support their well-being. Kimberly Miles Communications, LLC is not intended to replace either medical or dental treatment, or psychiatric help; it is your responsibility to seek appropriate medical, dental, and mental health intervention.

Kimberly K. Miles' intent is both to educate you and support you in your choices for developing a healthy and satisfying lifestyle. Kimberly K. Miles neither diagnoses nor treats illness and disease. Kimberly K. Miles and Kimberly Miles Communications, LLC shall have neither liability nor responsibility to any person or entity with respect to any damage, loss, consequences or injury, related to information given, including recommended products and services. I acknowledge that I understand all the questions. I have answered all questions completely and accurately to the best of my knowledge. I am fully aware that the success of my program depends upon taking responsibility for myself.

I understand and accept. Yes ☐ No ☐

Signed _____

Date _____