



Body Scan, Emotion Code, Heart-Wall, Body Code, and Belief Code  
Client Intake Form

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current Age: \_\_\_\_\_

**Please list the issues(s) and/or goal(s) you would like to work on. This can include:**

- Physical discomfort (aches, pains, etc.)
- Mental imbalances/discomfort (anxiety, depression, etc.)
- Goals you feel you have not been able to reach in the past

**Please also list how problematic, stressful, or difficult it has been for you on a scale of 1 – 10, with 1 being mostly minor and 10 being most severe.**

**Issue/Goal 1:** \_\_\_\_\_

Please list your symptoms: \_\_\_\_\_

How problematic, stressful, or difficult is this (1-10): \_\_\_\_\_

How long has this been going on? \_\_\_\_\_

**Issue/Goal 2:** \_\_\_\_\_

Please list your symptoms: \_\_\_\_\_

How problematic, stressful, or difficult is this (1-10): \_\_\_\_\_

How long has this been going on? \_\_\_\_\_

**Issue/Goal 3:** \_\_\_\_\_

Please list your symptoms: \_\_\_\_\_

How problematic, stressful, or difficult is this (1-10): \_\_\_\_\_

How long has this been going on? \_\_\_\_\_

**Do you have any medical devices (hearing aids, pacemaker, defibrillator, implanted device, insulin pump, etc.) that may be affected by the use of magnets?**

Yes       No

How did you hear about us? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_