The Resonance Repatterning™ System Client Intake Form

CLIENT NAME_____BIRTHDATE_____

ADDRESS_____

PHONE_____CELL_____

NEAREST CONTACT_____

Primary Care Physician_____

Therapist_____

Alternative Care_____

_____

Diagnosed Illness_____

Prescribed Medication_____

Supplements_____

What do you hope to accomplish in our work together?

SIGNED_____DATE_____