**Personal Intake Form – Flower Essence Consultation**

Name: Date:

Address:

DOB: Time of Birth (From Birth Certificate):

Place of Birth:

E-mail:

Phone: Gender/Preferred Pronoun/s: , \_\_\_\_\_\_\_\_\_\_

Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies/Interests/Main Activities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any specific medical diagnosis?

Are you currently under the care of a physician? Yes No

Have you ever used flower essences? Yes No

If yes, which ones?

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Do you need support for an immediate crisis? Yes No

If so, please describe:

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Are you interested in working with essences for long-term growth? Yes No

What goals would you like to focus on during session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Briefly describe your current experiences giving priority to what you would like support with:

**Physical** (ex. medical conditions, illness, diet, energy level, living situation, occupation, health)

**Emotional** (ex. relationships, strong feelings, general moods, self-expression, trauma, reactions)

**Mental** (ex. general thoughts, confusion, anxiety, attention span, memories, anticipation, stress)

**Spiritual** (ex. sense of purpose, belief system, values, awareness of self, devotional practices)