



Moksha Living L.L.C.

Moksha Therapy Services

Client Information

Date _____

Name: _____ I Prefer to be called: _____
 Address: _____ City: _____ State: _____ Zip _____
 Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
 The best time to contact me is: _____ A.M. P.M. on my Home phone Work phone Cell phone
 Date of Birth: _____ E-mail Address: _____ ok to e-mail: yes No
 Check Appropriate Box: Minor Single Married Widowed Separated Divorced
 If Student, Name of School _____ City/State _____ FT PT
 Whom may we thank for referring you? _____
 Person to contact in case of emergency _____ Phone _____

Personal Health Profile

How would you rate your physical health? Poor _____ Fair _____ Good _____ Excellent _____
 Please specify medical health concerns : _____
 Please describe any mental health concerns in your family history:
Family Member _____ Mental Health Concern: _____

 How much caffeine do you consume in the average week? amount: _____ frequency : _____
 How much alcohol do you consume in the average week? Amount: _____ frequency: _____
 How long and how many times per week do you exercise? _____
 Do you have any dietary/ eating concerns? (explain) _____
 On average, how many hours of sleep do you get per night? _____
 How satisfied are you with your quality and quantity of sleep?: dissatisfied ___ would like improvement ___ It's fine ___
 Past mental health care? Provider _____ Dates _____
 Provider _____ Dates _____
 Mental health diagnosis (if applicable): _____
 Have you ever contemplated or attempted to physically hurt yourself or someone else? _____
 If yes, please provide details: _____

Medical Information

Primary Care Physician: _____ Date of last visit: _____ Contact: _____
 Other treating speciality: _____ Date of last visit: _____ Contact: _____
 Current health supplements or medication: _____ dose: _____ frequency: _____
 _____ : _____ dose: _____ frequency: _____
 _____ dose: _____ frequency: _____