True Nutritionist Light Body Healer
7 West 30TH Street 11 floor Suite 6
518-810-4175 | www.elizabethmtripp.com

True Nutritionist Light Body Healer Intake Form:

Please print. Fill out the following form and bring it with you or email it to me upon your first visit.

Today's date:

Email:

First name:

Middle:

Last:

Marital status (circle one): Single / Married / Divorced / Separated / Widowed

Do you have children?

Are you currently receiving medical or mental health care? Yes No

If yes, what is the nature of the care?

Birth date:

Age:

Sex: M F

Do you engage in any self-development activities such as meditation, therapy, books, groups?

Street address: **State** **zip**

Cell phone no:

Home phone no:

Occupation:

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Who referred you (please circle one box): Friend Family therapist Other:

1. **Please take a moment to reflect deeper at what areas you would like to work on right now?** (Health/nutrition, self-esteem, career, family, relationships etc.)

2. **Are there any areas in your life that feel out of balance for you?**

3. **How would you like to be seen in the world?** (Fit, healthy, in good shape, kind, good natured, happy, successful etc..)

4. **What characteristics do you enjoy about yourself?**

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Disclaimer: You are advised to take any and all advice given in a session as purely metaphysical and not medical, psychiatric, and not as a substitute for professional counseling and care. Neither should you disregard the advice and treatment that you might be receiving from your doctor, therapist, psychiatrist or any other health provider whose care you are under. If you need immediate assistance, please call the nearest hospital or 911 for emergencies. Any information or advice given is not meant to, or should not be a substitute or used against, any professional advice given by either a doctor, psychiatrist, psychologist or any other professional. This is not meant to substitute your care by a trained and licensed mental health practitioner. I, Elizabeth Tripp or any one associated with me, will not accept responsibility for action that you might take from your visit that goes against the professional advice you receive from any licensed professional medical or legal. Any decision that you make is of your own free will and is solely your own responsibility. You have voluntarily contacted me or my associates for our services. All services are held in confidence and will not be disclosed unless otherwise required by law. Services will NOT be performed for persons under the age of 18 without written parental consent, faxed or mailed. By signing, you give me full permission to perform my services for you and have read, understand and accept this disclaimer. The above information is true to the best of my knowledge. By signing, I give full permission to be worked on as I request.

Signature or Guardian Signature Date: