

Bonnie Tollison, Licensed Heart Math Provider, CNHP
Stress Management Intake Form

Date: _____ Name: _____

Address: _____

Phone: (H) _____ (C) _____ (W) _____

Email Address: _____

Do you currently experience any of the following?

- | | |
|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Overly tired |
| <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Minor aches/pains | <input type="checkbox"/> Foggy thinking |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Home/work imbalance |

Other health issues/concerns: _____

List the 3 main stressors in your life:

- 1) _____
- 2) _____
- 3) _____

How do you currently handle your stress?

Is it effective? _____

Is that any aspect of your life that would improve if you learned to manage your stress better? _____

