CLIENT HISTORY

Name: …………………………………………………   Date: ………………………………

Date of Birth (early / due date / late):

Place of Birth (hospital / home):

Who was there:

Siblings before and after:

Any miscarriages before your birth:

Known issues during pregnancy:

Birth details (caesarean / breech / twin / etc):

Breastfed (and for how long):

Childhood illnesses:

Childhood traumas:

Teenage traumas:

Adult traumas:

Current illnesses:

Current medication:

Key issues:

What you want from Rebirthing: