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CLIENT INTAKE FORM

Please update me on any changes in your contact information!

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ OCCUPATION: _____

REFERRED BY: _____

CONTACT INFORMATION

Are confidential messages OK? Yes ___ No ___

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

Please indicate if confidential messages should not be left at any of these

EMERGENCY CONTACT

NAME: _____

PHONE(S): _____

RELATIONSHIP: _____

PLEASE LIST THE NAME and specialties of other health care professionals you are currently seeing, as well as the name of your primary physician and approximate date of your last physical exam:

_____
_____
_____

PLEASE READ CAREFULLY

I understand that the energy healing sessions I receive are provided for the basic purpose of harmonizing my body's energies. If I experience any pain or discomfort during a session, I will immediately inform my practitioner.

I further understand that energy healing should not be construed as a substitute for needed medical attention. Energy healing practitioners do not diagnose, treat, or prescribe for medical conditions. Energy healing brings about physical improvements by impacting the electromagnetic fields that regulate the body as well as by shifting the more subtle energies described in other cultures with terms such as chakras, meridians, and etheric fields.

SIGNATURE: _____ DATE: _____

What do you hope to gain from your energy healing sessions?

Describe problems you wish to address. Include how long you have had them, any medical or psychological diagnosis for them, treatments you have tried, and their effectiveness:

Do you have a Pacemaker? ____
Do you have Metal Plates or Screws in your body? ____
Do you have Diabetes? ____
Are you pregnant? ____

FAMILY MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures
Asthma Allergies Mental Illness Other Significant Illnesses (please list):

YOUR MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures
Asthma Allergies Mental Illness Other Significant Illnesses (please list on next page):

SURGERIES	DATES

Describe any major accidents or traumatic events and approximate dates:

ALLERGIES (drugs, chemicals, foods, airborne allergies, etc.)

CURRENT MEDICATIONS

NAME	PURPOSE	DOSAGE AND FREQUENCY	TAKEN FOR HOW LONG	ANY ADVERSE REACTIONS?

CURRENT NUTRITIONAL AND HERBAL SUPPLEMENTS (use back if necessary)

NAME	PURPOSE	DOSAGE AND FREQUENCY	TAKEN FOR HOW LONG	ANY ADVERSE REACTIONS?

PLEASE CIRCLE	WHAT KIND?	HOW OFTEN? PER DAY/PER WEEK
ALCOHOL		
CAFFEINE/COFFEE		
SODA		
CIGARETTE TOBACCO		
OVER-THE-COUNTER MEDICATIONS		

All answers on this form are confidential.

PLEASE CIRCLE THOSE THAT APPLY	LAST USED	AMOUNT USED	FREQUENCY PER DAY/PER WEEK	ANY ADVERSE REACTION
MARIJUANA				
AMPHETAMINES				
COCAINE				
OTHER				

What gives you joy?

How do you deal with stress?

How do you relax?

How do you take care of your body?

Are there any other issues you would like to discuss?