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CLIENT INTAKE FORM

Name _____ Date _____

Address _____ City/State _____

Cell # _____ Email _____

Referred by _____ Newsletter Y/N

Emergency Contact: _____ Relationship: _____

Emergency contact phone: _____

PLEASE READ CAREFULLY

Although Energy Medicine uses the term "medicine," it does not imply that Energy Medicine practitioners are practicing medicine. Energy Medicine is a term used by many training programs that teach people how to assess and correct for energy imbalances in the body. Energy Medicine is not a substitute for the diagnosis and/or treatment of medical or mental health conditions by a licensed health care professional. If you have a disorder that has been diagnosed by a licensed medical or mental health professional or a condition that should be evaluated by a licensed health professional, my services should be used only in conjunction with your obtaining that care. I do not diagnose or treat medical or mental health disorders, nor am I trained or licensed to do so. Energy Medicine attempts to optimize the body's overall health and vitality, but it is not used instead of appropriate care from a licensed professional. If you experience any pain or discomfort during your session you argree to inform me immedatiately. I also understand that COVID-19 has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to person contact; and, as a result, federal and state health agencies recommend social distancing. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive a session from this practitioner.

_____ _____
Print Name Date

_____
Signature

Have you had a cough or sore throat? Y / N
Have you had a fever or do you feel feverish? Y / N
Do you have shortness of breath? Y / N
Do you have a loss of taste or smell? Y / N
Have you been around anyone exhibiting these symptoms within the past 14 days? Y / N
Are you living with anyone who is sick or quarantined? Y / N
Have you been out of state in the last 14 days? Y / N

Are you pregnant? Y / N
Do you have a pacemaker? Y / N
Do you have any metal plates or screws in your body? Y / N
Are you on prescription medication? Y / N

YOUR MEDICAL HISTORY (please circle)

Diabetes
Cancer
High Blood Pressure
Heart Disease
Stroke
Seizures

Asthma
Allergies
Surgeries
Autoimmune Disease - if yes, specify

Other illness:

What are the primary problems that you wish to address?

How long have you had them?

What other things have you tried to solve them?

How do you deal with stress?

Is there anything you would like to note that is not on this form?