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CLIENT INTAKE FORM

Name _____ Date _____
Address _____ City/State _____
Cell # _____ Email _____
Referred by _____ Join 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 agree to inform me immediately. 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

SERVICE AGREEMENT & INFORMED CONSENT

Welcome to Mariposa Energy Medicine and Health Coaching practice. This Service Agreement (hereafter referred to as "The Agreement") constitutes a contract between Paula Apro, EEM (hereafter referred to as "The Practitioner") and _____ (hereafter referred to as "The Client"). As The Client, you should read it carefully and raise any questions and concerns that you may have before you sign it.

Services: The services provided by Paula Apro include energy healing modalities (Eden Energy Medicine, Pranic Healing, Emotion Code™, Bio-Well Health Assessments, Crystal Sonic Rejuvenation Facials) and Quantum Health Coaching. Many of these services can be performed in-person or remotely at a distance.

Purpose/Mission: The purpose of this practice is to help you to realize and unleash your full potential in order to optimize and/or restore your health. We will achieve this using a new paradigm of Health based on the premises of Quantum Physics and Neuroscience.

Confidentiality: It is my duty to protect the confidentiality of the communications with my clients. I will only release information about our work to others with your written permission or if I am required to do so by a court order. The Client should be aware that it is impossible to protect the confidentiality of Client information which may be transmitted electronically, i.e., e-mail and text.

Mutual Nondisclosure: The Practitioner and The Client mutually recognize that they may discuss The Client's future plans, business affairs, financial information, job information, goals, personal information, and other private information. The Practitioner will not voluntarily communicate The Client's information to any third party. In order to honor and protect the Practitioner's intellectual properties, The Client expressly agrees not to disclose or communicate any proprietary information about the Practitioner's practice, materials, or methods to any third parties. The Practitioner and The Client agree to be bound by this mutual nondisclosure agreement during and after the termination of the professional relationship.

Dispute Resolution: It is agreed between The Client, his or her assigns, family and estate and The Practitioner that any controversy or claim arising out of or relating to The Agreement, or the breach of this agreement, shall be settled by arbitration by an accredited individual or organization with an arbitrator whom we mutually agree upon. Your signature below, as The Client, acknowledges that you have read the information contained in The Agreement and Informed Consent; and signifies your assurance that you will abide by its terms during our professional relationship. Please request an electronic copy of this Agreement should you want one for your records.

The Client_____ Date _____

The Practitioner_____ Date _____

COVID Specific

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

What are the primary reasons for your visit? What is it that you hope to resolve?

How would your life improve if your issue(s) were resolved? What is it stopping you from doing, having or achieving?

Have you tried other things to reach your health goals? If so, what?

On a scale from 1 - 10 how ready are you to make a change in your health and lifestyle?

How do you deal with stress?

What brings you joy?

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