CLIENT INTAKE FORM

ENERGY WORK INTAKE FORM

ABOUT YOU

NAME

EMAIL

ADDRESS	CITY	STATE	ZIP

OCCUPATION	DATE OF BIRTH

HOW DID YOU HEAR ABOUT US?

MOBILE PHONE	HOME PHONE	WORK PHONE

EMERGENCY CONTACT NAME & TELEPHONE NUMBER

HOW WOULD YOU LIKE TO BE NOTIFIED OF YOUR APPOINTMENTS?

❑ TELEPHONE ❑ EMAIL ❑ TEXT MESSAGE - *PLEASE INDICATE PHONE CARRIER:*

HAVE YOU HAD ENERGY WORK BEFORE?

DO YOU HAVE ANY GOALS FOR TODAY'S SESSION?

HEALTH HISTORY

MEDICAL CONDITIONS - PLEASE CHECK ALL CONDITIONS THAT APPLY

CIRCULATORY

❑ HEART CONDITION/ ARRHYTHMIA
❑ PHLEBITIS/ VARICOSE VEINS
❑ HIGH/ LOW BLOOD PRESSURE
❑ CIRCULATION PROBLEMS

MUSCULOSKELETAL

❑ SPINAL PROBLEMS

REPRODUCTIVE

❑ PREGNANCY

RESPIRATORY

❑ ASTHMA

SKIN

❑ CONTAGIOUS SKIN CONDITIONS
❑ OPEN SORES OR WOUNDS
❑ RASHES
❑ ALLERGIES

DO YOU WEAR ANY OF THE FOLLOWING:

❑ CONTACT LENSES
❑ ORTHOPEDIC DEVICE IN SHOES
❑ HEARING AIDS

STRESS LEVEL:

❑ LOW ❑ MEDIUM ❑ HIGH

OTHER

❑ CANCER/ TUMORS
❑ CHRONIC FATIGUE
❑ CHRONIC PAIN/ FIBROMYALGIA
❑ CURRENT COLD/ FLU/ FEVER
❑ CONTAGIOUS DISEASES
❑ ABDOMINAL/ BACK PAIN
❑ FAINTING/ DIZZINESS/ VERTIGO
❑ SENSITIVITY TO HEAT/ COLD
❑ TRAUMA OVER THE PAST YEAR

READ

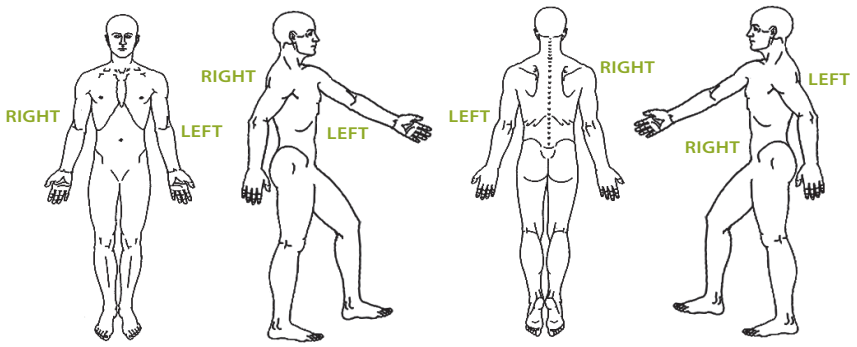
PLEASE READ

REIKI AND ENERGY HEALING SHOULD NOT BE USED TO TREAT OR DIAGNOSE DISEASE AND IS NOT MEANT TO BE AN INDEPENDENT GUIDE FOR SELF-HEALING. IF YOU HAVE A HEALTH CONDITION OR CONCERN, PLEASE SEEK THE CARE OF A LICENSED MEDICAL DOCTOR OR HEALTHCARE PROFESSIONAL.

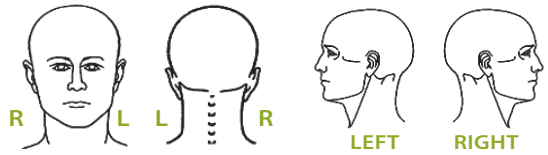
CHARTING

OOOOOO XXXXXX PLEASE **CIRCLE** ALL AREAS YOU WISH TO BE ADDRESSED AND **CROSS OUT** ANY AREAS YOU WISH TO BE AVOIDED OOOOOO XXXXXX

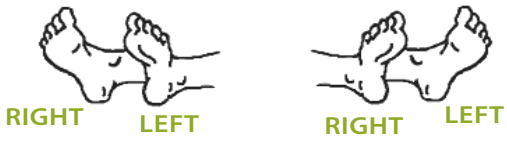
FULL BODY - FRONT/BACK & SIDES



HEAD AND NECK



FEET



THERAPY

TYPE OF THERAPIES YOU ARE RECEIVING TODAY: (INDICATE ALL THERAPY TYPES)

- ❑ INTUITIVE ENERGY HEALING
- ❑ REIKI
- ❑ CHAKRA BALANCING
- ❑ AURA CLEARING
- ❑ SOUND HEALING
- ❑ OTHER _____

THERAPEUTIC AGREEMENT

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I, _____ understand that the body therapy given here is for the purpose of promoting: natural structural balance, pain reduction, relief of muscular tension or spasm, stress reduction, and increasing circulation.

I understand that the therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulation. I understand the services are designed to be a health aid and are in no way to take the place of doctor's care when it is indicated. Information exchanged during any session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Because a therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical needs.

I will indicate to the therapist ***anything*** that makes me feel uncomfortable. I understand that either I, or the therapist, have the right to terminate a session.

CLIENT SIGNATURE _____ DATE _____

THERAPIST SIGNATURE _____ DATE _____

MINOR CONSENT

CONSENT TO TREATMENT OF A MINOR:

By my signature below, I hereby authorize the therapist to administer body therapy to my child or dependant, as they deem necessary.

SIGNATURE OF PARENT OR GUARDIAN: _____ DATE _____

POLICIES & FEES

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CANCELLATION: Clients must cancel appointments 24 hours in advance. Appointments cancelled in less than 24 hours must be paid in full. ***Multiple missed appointments or late cancellations will result in no future appointments.***

APPOINTMENT TIME: Sessions run approximately 50 minutes for an hour and 25 minutes for a half hour. Late arrivals will only receive the remainder of their allotted time, but will be responsible for paying the full amount of their session.

PAYMENT: Payment is due at the end of each session. We do not participate in any medical insurance plans. A $25 fee will be charged for checks returned by the bank.

The information contained within will be used to determine appropriate assessment and course of treatment. The information obtained is confidential and will only be released with written authorization from the client. It is requested that you update your case history and inform your health care provider should your health status change.

I have read the above policies and understand them clearly.

SIGNATURE _____ DATE _____