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Telephone: 443.786.0472

CLIENT INTAKE FORM

The more information provided, the more complete our assessment. If you received by email, please complete, print and bring with you for your initial appointment or email in advance. Please update me on any changes in your contact information! Thank you.

DATE: _____
NAME: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____
BIRTH DATE: _____ SOCIAL SECURITY #: _____

OCCUPATION: _____

REFERRED BY: _____

CONTACT INFORMATION
Are confidential messages OK? Yes ___ No ___
HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ e-ADDRESS: _____

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:

What do you hope to gain from your energy medicine 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 scars on your body? ____ Where? ____
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		
CIGARETTES/TOBACCO		
OVER-THE-COUNTER MEDICATIONS		

All answers on this form are confidential. However; if substance-use appears to be *life threatening*, I am required by law to report it.

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?

PLEASE READ CAREFULLY

I understand that the energy medicine 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 medicine should not be construed as a substitute for needed medical attention. Energy medicine practitioners do not diagnose, treat, or prescribe for medical conditions. Energy medicine 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: _____