

Date: **Client Name** \_\_\_\_\_

Address:

Home Phone:

Cell Phone:

Work Phone:

Email:

Emergency contact name & phone:

DOB: Age: Gender: M F

Legal guardian if under 18:

Referred by:

Client Informed Consent signed  Yes  No OK to add to contact database?  Yes  No

Occupation: Employer:

Family / Relationship status:

Military History - Branch of service and years:

Prior Energy Therapy/work experienced:

Current overall health condition: \_\_Excellent \_\_Very Good \_\_Good \_\_Fair \_\_Poor

To what do you attribute your current situation, symptom or health issue?

**Mark the primary reasons for seeking Energy Therapy:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Increase relaxation  | <input type="checkbox"/> Chronic Illness / Disease | <input type="checkbox"/> Emotional Support        |
| <input type="checkbox"/> Stress Management    | <input type="checkbox"/> Surgery Support           | <input type="checkbox"/> Spiritual Support        |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Cancer Treatment Support  | <input type="checkbox"/> Major Life Change / Loss |
| <input type="checkbox"/> Pain Management      | <input type="checkbox"/> Back Pain                 | <input type="checkbox"/> Other (list):            |
| <input type="checkbox"/> Headaches            |  |   |

**With the following scale, rate the areas of concern at this time:**

**Blank = None 1 = Minimal 2 = Moderate 3 = High 4 = Very High 5 = Extreme**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Personal Relationships  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Headaches          |
| <input type="checkbox"/> Physical Health         | <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Pain               |
| <input type="checkbox"/> Mental/Emotional Health | <input type="checkbox"/> Anger issues             | <input type="checkbox"/> Fatigue / Lethargy |
| <input type="checkbox"/> Work                    | <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Hormonal Issues    |
| <input type="checkbox"/> Finances                | <input type="checkbox"/> Panic or Anxiety Attacks | <input type="checkbox"/> Sleeping Issues    |
| <input type="checkbox"/> Eating Issues           | <input type="checkbox"/> Emotional Trauma / PTSD  | <input type="checkbox"/> Other (list)       |
| <input type="checkbox"/> Addiction               | <input type="checkbox"/> Memory Problems          |   |

Current self care practices (exercise, meditation, relaxation, body care, journaling, etc):

Hobbies & interests:

Spiritual beliefs, practices, affiliations:

**Relevant Health History**

Primary physician or health care professional:

Last physical:

Other health care professionals you currently see:

Current or chronic medical conditions, diagnosis, or treatments with dates:

Mental health issues or diagnoses:

Hospitalizations and/or surgeries (condition & year):

Significant physical or emotional traumas (condition & year):

Allergies:

Current prescription medications:

Current Supplements Used:

Vitamins    Minerals    Herbs    Homeopathics    Flower Essences    Other

Sleep quality & sleep aid usage:

Other relevant conditions/information:

**Nutrition**

Quality of diet:

Special dietary needs:

Daily water amount:

Daily caffeine amount:

Alcohol & recreational drug usage / amount:

Tobacco usage / amount:

**Is there anything else you want me to know?**