

Client Information for: _____

Date:

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

Occupation:

Employer:

Relationship/Family status:

Military History - Branch of service and years:

Prior Energy Therapy/work experienced:

Current health condition: __Excellent __Very Good __Good __Fair __Poor

What is your primary reason for seeing Energy Therapy:

- | | | |
|---|--|---|
| <input type="checkbox"/> Relaxation | <input type="checkbox"/> Chronic Illness / Disease | <input type="checkbox"/> Emotional Support |
| <input type="checkbox"/> Major Life Change / Loss | <input type="checkbox"/> Surgical Support | <input type="checkbox"/> Spiritual Support |
| <input type="checkbox"/> Physical Pain / Issue | <input type="checkbox"/> Medical Procedure Support | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Cancer Treatment Support | <input type="checkbox"/> Anxiety / Depression |
| <input type="checkbox"/> Other (list): | | |

Please use the following scale to rate any 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"/> Your Health | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Work | <input type="checkbox"/> Anger issues | <input type="checkbox"/> Fatigue / lethargy |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hormonal issues |
| <input type="checkbox"/> Other (list) | <input type="checkbox"/> Panic or anxiety attacks | <input type="checkbox"/> Sleeping issues |
| | <input type="checkbox"/> Emotional trauma / PTSD | <input type="checkbox"/> Eating issues |
| | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Addiction |

Continued on back

Sue Walker ∞ **Wellness Within**^{LLC}

Healing Touch Certified Practitioner (HTCP) ∞ Certified Reiki Master (CRM)

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

Hobbies & interests:

Spiritual beliefs/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:

Mental health issues or diagnoses:

Hospitalizations or surgeries (condition & date):

Significant traumas (physical and/or emotional):

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:

Other information:

03.01.10

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