Energy for You
www.Nrg4U.org

CLIENT INTAKE FORM

Please update me on any changes in your contact information!

Date: _____

Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Birth Date: _____ Current Age ____ Social Security #: _____

Occupation: _____

Referred by: _____

Contact information

Home phone: ❒_____ Work phone: ❒_____

Cell phone: ❒_____ email: ❒_____

Please check the box if confidential messages may be left at any of these contact points.
Please circle your preferred contact method.

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:

_____

_____

_____

_____

_____

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: _____

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 Metal Plates or Screws in your body? ____
Do you have Diabetes? ____
Are you pregnant? ____

FAMILY MEDICAL HISTORY (please circle all that apply)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

Asthma Allergies Mental Illness Other Significant Illnesses (please list):

<u>YOUR</u> MEDICAL HISTORY (please circle all that apply)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

Asthma Allergies Mental Illness Other Significant Illnesses (please list):

SURGERIES	DATES

Briefly describe any major accidents or traumatic events and approximate dates:

ALLERGIES (drugs, chemicals, foods, airborne allergies, etc.)

How much plain water do you drink per day ? _____

Water source? (Please circle) Tap, Filtered (Type of filter_____), Well, Spring, Distilled, Sparkling, Other _____

Current prescription medications/hormones

NAME / DOSAGE	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?

CIRCLE IF USED	WHAT KIND?	HOW OFTEN? PER DAY/PER WEEK
ALCOHOL		
CAFFEINE/COFFEE/TEA		
SODA		
ARTIFICIAL SWEETENERS		
CIGARETTES/TOBACCO		
WHEAT (GRAINS, BREADS)		
ENERGY DRINKS		
OVER-THE-COUNTER MEDICATIONS		

What food(s) do you crave? _____

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 ALL THAT APPLY	**LAST USED**	**AMOUNT USED**	**FREQUENCY PER DAY/PER WEEK**	**ANY ADVERSE REACTION**
MARIJUANA				
AMPHETAMINES				
COCAINE				
OTHER				

What gives you joy?

What is your biggest stress?

How do you deal with stress?

Where does your body hold stress?

How do you relax?

How do you take care of your body?

Are there any other issues you would like to discuss?