Aligned Energetics
ENERGETIC KINESIOLOGY FOR SPIRIT, SOUL & BODY

WELLNESS INTAKE FORM

Date : _____ / _____ / _____

PERSONAL INFORMATION

Full Name :

Address :

City : **State :** **Zip Code :**

Email : **Phone :**

Occupation : **Best Way to Contact :**

Date of Birth : **Age :** **Occupation :**

Marital Status : ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Seperated **# of Children :**

Method of Payment: ☐ Venmo ☐ Paypal ☐ CashApp ☐ Other **Account Name :**

EMERGENCY CONTACT DETAILS

Contact Name :

Relationship : **Phone Number :**

HEALTH QUESTIONS

Health concerns for which you came in today: :

When did the conditions develop & describe the symptoms & diagnosis given:

What makes this condition worse? :

List treatment currently prescribed for this condition: :

Describe results of previous treatment(s) : Chriopractic, massage, PT,etc)

Are you presently under a physician's care : (Other then Annual physicals) ☐ YES ☐ NO

If yes, please Explain :

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HEALTH QUESTIONS

List surgeries, accidents & illness (dates) : _____

_____

List medications & reason for their use : _____

_____

List over-the-counter medications and supplements : _____

_____

Do you regularly drink caffeine beverages ☐ None ☐ coffee ☐ tea ☐ soda ☐ energy drink ☐ other

Do you smoke? : ☐ YES ☐ NO **If so how many packs a day? :** _____

Do you drink? : ☐ YES ☐ NO **If so how many a day? :** _____

Are you pregnant? : ☐ YES ☐ NO **If so when are you due ?:** _____

Are you participating in a regular fitness program? ☐ YES ☐ NO

If so, please describe ? : _____ :

_____

How many hours a night do you sleep?: _____ **Is your sleep restful? :** ☐ YES ☐ NO

If not, at what times or how ofted do you wake? : _____

_____

Do you have trouble : ☐ falling asleep ☐ staying asleep ☐ neither **Water intake? :** _____

Do you have any medical conditon and/or physical limitation that your practitioner needs to be aware of before you receive treatment? : _____

_____

PLEASE CHECK ALL THE AREAS OF PAIN BELOW

Upper Body	Back	Arms			Legs		
☐ Head	☐ Upper	☐ Shoulder	☐ Left	☐ Right	☐ Hip	☐ Left	☐ Right
☐ Neck	☐ Middle	☐ Elbow	☐ Left	☐ Right	☐ Knee	☐ Left	☐ Right
☐ Chest	☐ Lower	☐ Wrist	☐ Left	☐ Right	☐ Ankle	☐ Left	☐ Right
☐ Abdomen	☐ Sacrum	☐ Hand	☐ Left	☐ Right	☐ Foot	☐ Left	☐ Right

Other: _____

_____

_____

Please check all the following feelings you have experienced in last few months

☐ Abused	☐ Rejected	☐ Overwhelmed	☐ Unable to grieve	☐ Fearful	☐ Intolerant	☐ Outraged
☐ Criticized	☐ Despair	☐ Criticized	☐ Apprehensive	☐ Impatient	☐ Uncertainty	☐ Nervous
☐ Overworked	☐ Helpless	☐ Overworked	☐ Agitated	☐ Intimidated	☐ Aggrivated	☐ Worry
☐ Paralyzed	☐ Hopeless	☐ Paralyzed	☐ Uneasy	☐ Restless	☐ Annoyed	☐ Anxiety
☐ Depressed	☐ Paranoid	☐ Depressed	☐ Distress	☐ Panic	☐ Angry	

Please check all the Symptoms you experience

Sometimes Often Past (Leave BLANK if NEVER)

S	O	P		S	O	P	
☐	☐	☐	Loose Stools/Diarrhea	☐	☐	☐	Cough
☐	☐	☐	Flatulence	☐	☐	☐	Shortness of Breath
☐	☐	☐	Vomiting	☐	☐	☐	Decreased sense of smell
☐	☐	☐	Belching, Burping	☐	☐	☐	Nasal Problems
☐	☐	☐	Heartburn	☐	☐	☐	Skin Problems
☐	☐	☐	Feeling of distention after meal's	☐	☐	☐	Bronchitis
☐	☐	☐	Obsessive in work/ relationships	☐	☐	☐	Asthma
☐	☐	☐	Fatigue	☐	☐	☐	Tendency to catch cold easily
☐	☐	☐	Edema	☐	☐	☐	Intolerant to weather changes
☐	☐	☐	Easily Bruised	☐	☐	☐	Allergies
☐	☐	☐	Difficult to stop bleeding	☐	☐	☐	Hay Fever
☐	☐	☐	Low back pain	☐	☐	☐	Irritable Bowel
☐	☐	☐	Knee problems	☐	☐	☐	Constipation
☐	☐	☐	Hearing impairment	☐	☐	☐	Hemorrhoids
☐	☐	☐	Ringing in ears	☐	☐	☐	Blood in stools
☐	☐	☐	Kidney stones	☐	☐	☐	Eye Problems
☐	☐	☐	Decreased sex drive	☐	☐	☐	Dizziness
☐	☐	☐	Hair loss	☐	☐	☐	Hepatitis
☐	☐	☐	Urinary problems	☐	☐	☐	Difficult digesting oily foods
☐	☐	☐	Insomnia, difficulty sleeping	☐	☐	☐	Gall stones
☐	☐	☐	Heart palpitations	☐	☐	☐	Light colored stools
☐	☐	☐	Excessive dreaming	☐	☐	☐	Soft or brittle nails
☐	☐	☐	Restless	☐	☐	☐	Easily angered/ irritated
☐	☐	☐	Chest pains	☐	☐	☐	Difficulty making plans or decisions
☐	☐	☐	Tendency to faint easily	☐	☐	☐	Muscle spasms/ twitching
☐	☐	☐	High Blood pressure	☐	☐	☐	Headaches
☐	☐	☐	Abdominal hernia	☐	☐	☐	High cholesterol
☐	☐	☐	Arthritis	☐	☐	☐	Neck pain
☐	☐	☐	Sciatica	☐	☐	☐	PMS
☐	☐	☐	Bursitis	☐	☐	☐	Sever Menstrual pain
☐	☐	☐	Blood clots	☐	☐	☐	Foot numbness
☐	☐	☐	Broken bones	☐	☐	☐	Carpal tunnel syndrome
☐	☐	☐	Hand/feet cold	☐	☐	☐	TMJ (Temporal-mandibular joint)
☐	☐	☐	Hand numbness	☐	☐	☐	Loss of Balence
☐	☐	☐	Cancer	☐	☐	☐	Diabetes
☐	☐	☐	Herniated disc	☐	☐	☐	Varicose veins

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INFORMED CONSENT FORM

I understand that Nicole Hatten is a Licensed Pastor in the State of Oklahoma.

1. I understand that Nicole Hatten, energy and detox specialist is qualified to help me relax, reduce stress, and manage pain, enhance the quality of my life, detoxify my body of toxic pollutants in order to help me improve my bodies performance.
2. I understand that if I have -- or if I think I have -- a medical concern, condition, disease, disorder, issue or symptoms, Nicole Hatten will help me reduce any related stress and refer me to a licensed chiropractic, medical or osteopathic physician for further assistance.
3. I also understand if I have -- or if I think I have -- a psychological or emotional concern, condition, disease, disorder, issue or symptoms, Nicole Hatten will help me reduce any related stress and refer me to a licensed counselor, psychologist or psychiatrist for further assistance.
4. I understand it is my responsibility to advise my coach of anything that might help us work together better to achieve the results I seek.
5. I understand natural healing is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
6. I understand that natural healing methods are to aid my body in the detoxification process and to help my body achieve balance.
7. I understand that all the processes of healing may cause me some minor discomfort and some adverse side effects may occur through no fault of my own. I also understand that in no way is my coach teaching me anything that will purposefully bring about discomfort. I also understand some interventions have contraindications and I will be fully advised of these contraindications. I further understand that these services may have no effect on me.
8. I will keep my coach fully advised about my concerns, so the session may be terminated or, if necessary, revised in order to prevent or eliminate any discomfort or harm to me.
9. I understand Nicole Hatten will keep all information she learns about me completely confidential unless I release her in writing or as required by law. I further understand my Nicole Hatten will not discuss anything with me publicly unless I initiate the conversation and the topics of discussion.
10. I understand that my identity and any information about me, will be held in the strictest confidence except when released by me or specifically required by law.
11. I understand that my own health and wellness is my responsibility. Therefore, I agree to use the services of Nicole Hatten to help me learn and improve my wellness using the techniques and modalities listed herein.

I acknowledge that I have read and understand this form. I agree to allow Nicole Hatten to help me learn to lower my stress and discomfort by using the natural healing techniques and modalities.

Name of Client _____

Address_____

State/Province _____ Postal Code _____ Country _____

Signature _____ Date _____

Relationship to client _____

Legal Guardian if under 18 years old _____