CLIENT INTAKE FORM

DATE _____

NAME _____

ADDRESS _____ CITY/STATE/ZIP _____

BIRTH DATE_____OCCUPATION _____

REFERRED BY _____

CONTACT INFORMATION: Are confidential messages OK? Yes_____ No_____

CELL PHONE _____ EMAIL ADDRESS _____

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 Eden 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 EEM 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 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)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma

Allergies Other Significant Illnesses: _____

YOUR MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma

Allergies Other Significant Illnesses: _____

Surgeries	Dates

Describe any major accidents or traumatic events and approx. dates:

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

Current Medications:

Name	Purpose	Dosage / Frequency Taken	For how long	Any adverse reactions?

Current Nutritional And Herbal Supplements (use back if necessary):

Name	Purpose	Dosage / 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		

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?