Energy Therapy/Consultation Form

Please Put your Personal Information on this page and sign the bottom

Your Practitioner_____

Your Name_____ Address_____

Telephone _____ Age____Email_____

Living Situation_____Occupation_____

Spiritual Practice_____ Physician_____

Other health providers_____

Presenting Concern/Issue_____
_____
_____

(This box is for the practitioner to complete)
Mutual Goals: _____
_____
_____

Medical History:
Heart_____ Liver/gall bladder_____ Kidneys_____
Thyroid_____ Nervous system_____ Headaches_____
Stomach_____ Pancreas_____ Colon_____
Lungs_____ Back and joints_____ Reproductive system_____
Surgeries_____
Accidents_____
Current Medications_____
_____

Systems Assessment:
Appetite_____ Digestion_____Respiratory_____
Lymphatic_____ circulation_____
Skin: Normal_____ Dry/sensitive_____ Oily_____ combination_____
Other skin conditions_____
Muscular-skeletal injuries_____ Stiffness_____ Pain_____
Arthritis_____ Menstrual cycle: regular_____ Dysmenorrhea/PMS_____
Menopausal difficulties_____
Male: Prostate_____ Impotence_____ Other_____
Stress Level: (tell me about your stress level at home and at work_____
_____
_____
_____

Self Care Activities: (What do you do to deal with your stress level)_____
_____
_____
_____

Client Signature_____ date_____