Client History Form

Name: Email Address:

Street Address: City:

State: Zip Code: Age: Date of Birth:

Phone #: Referred By:

Part 1. General Health History

Describe the symptom(s), problem(s) for which you seek help.

Describe past medical history (diagnosed conditions, previous injuries, accidents, surgeries, hospitalizations, illnesses, scars, etc.). Include approximate dates and if complications.

List all medications, prescriptions, supplements you are taking, including antibiotic even in the past, (as best you can).

List any known allergies (food, pets, environment, etc.).

List any significant stress or trauma from your past (divorce, abuse, mental illness, pregnancies, miscarriages, infant loss, births, etc.).

Please select your level of stress:

My family stress is:

My relationship stress is:

My work stress is:

My financial stress is:

My health stress is:

Other stress is:

Please list and describe any additional stresses in your life and the severity.

What are your current self-care practices and the time you devote to these practices (i.e., exercise, meditation, relaxation, journaling, hobbies, etc.)

What are your average hours of sleep per night:

Is your sleep restful?

If not, please explain:

Describe your typical diet (foods/beverages you avoid, foods/beverages you crave, etc.). Please include coffee, tea, alcohol and how often you consume.

Part 2. Family & Childhood

In a few sentences, describe your relationship with your mother during your childhood (from your perspective).

In a few sentences, describe your relationship with your father during your childhood (from your perspective).

In a few sentences, describe what it was like to grow up in your family.

Have you ever been the victim of abuse or neglect? If so please explain.

Part 3. Recent Emotions

Please check any of the following feelings you have experienced in the last few months.

Abused ☐	Paranoid ☐	Unable to grieve ☐	Panic ☐
Criticized ☐	Overwhelmed ☐	Apprehensive ☐	Intolerant ☐
Overworked ☐	Confused ☐	Agitated ☐	Uncertainty ☐
Paralyzed ☐	Persecuted ☐	Uneasy ☐	Aggravated ☐
Depressed ☐	Guilty ☐	Distress ☐	Annoyed ☐
Rejected ☐	Easily irritated ☐	Fearful ☐	Angry ☐
Despair ☐	Anxious ☐	Impatient ☐	Outraged ☐
Helpless ☐	Sad ☐	Intimidated ☐	Nervous ☐
Hopeless ☐	Grieving ☐	Restless ☐	Worried ☐

Part 4. Pain

Please list any areas of pain or discomfort in the body. Rate each area according to the scale below and list details, if necessary.

Rating:
1. Slightly aware of discomfort
2-3. Aware of discomfort as an aggravation
4-6. Pain is strong but you are still functional
7-9. Pain is so strong you are unable to function normally
10. You feel like you need to go to emergency room

Areas of pain and discomfort and rating from 1-10:

Part 5. Transformation

What change would you like to see in yourself as a result of energy healing sessions?

You may list your goals, concerns, and questions here or anything else you want me to know.

By providing my signature below, I confirm that the information recorded above is complete, accurate, and honest to the best of my knowledge. I understand that energy healing therapies are not a replacement for medical treatment, and that Pure Balanced Energy, LLC may only perform treatments within their scope of practice and level of comfort. Anything said during this session shall not be regarded as medical advice, treatment, diagnosis, or prescription. I understand that Pure Balanced Energy, LLC may refuse service at any time for any reason, and that clients may be referred to a medical professional if the need is necessary. I understand that it is my responsibility to inform Pure Balanced Energy, LLC of any changes to my medical health profile and that Pure Balanced Energy, LLC will not be held liable for anything resulting from my failure to do so. I agree that I have been given sufficient opportunity to ask questions and make specific requests in order to make my treatment time as comfortable as possible. I have also read and will abide by all policies and client expectations that may be listed separately from this document.

Client Signature: Date:

☐ Check here if you are signing as the legal guardian for a minor under the age of 18.)