Sweet Energies, LLC

CLIENT INTAKE FORM

Please update me on any changes in your contact information!
Your information will not be shared with anyone without your written consent.

DATE: _____

NAME: _____ EMAIL: _____

ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

BIRTH DATE: _____ OCCUPATION: _____

REFERRED BY: _____

CONTACT INFORMATION

Are confidential messages OK? Yes ___ No ___

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

Please indicate if confidential messages should not be left at any of these places.

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. (These professionals will not be contacted without your written permission)

PLEASE READ CAREFULLY

I understand that the Eden Energy Medicine (aka energy health) 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. There may be times when shifting energies may lead to temporary physical or emotional distress. I will communicate with my practitioner if I have any concerns about what I am experiencing.

I further understand that energy health sessions should not be construed as a substitute for needed medical attention. Energy health practitioners do not diagnose, treat, or prescribe for medical conditions. Energy health sessions 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 health 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:

FAMILY MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

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

YOUR MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

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

PLEASE LIST ANY SURGERIES – DATES AND OUTCOMES

Describe any major accidents or traumatic events and approximate dates:

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

CURRENT MEDICATIONS (use back if necessary)

Name	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

PLEASE CIRCLE	What kind?	How often? Per day/per week
Alcohol		
Caffeine/Coffee		
Soda		
Cigarettes/Tobacco		
Over-the-Counter Medications		

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 THOSE THAT APPLY	Last used	Amount used	Frequency Per day/per week	Any adverse reaction
Marijuana				
Amphetamines				
Cocaine				
Other				

What gives you joy?

How do you deal with stress?

How do you relax?

How do you take care of your body?

List past or present recurrent dreams you have had.

Are there any other issues you would like to discuss?

I look forward to partnering with you on your healing path. You will be taught or referred to self-care exercises that can improve your health and well being. By learning to direct and evolve your own energies you are empowered to actively participate in your healing process. I am always happy to refer you to resources to deepen your knowledge and understanding of energy healing.

Stacy L. Newman