# 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.***

NAME: ___________________________________________

EMAIL: ___________________________________________

ADDRESS: ____________________________________________________________

CITY:_______________________________ STATE: ________ ZIP: ______________

BIRTH DATE: ______________ OCCUPATION: _______________________________

REFERRED BY: ________________________________________________________

## CONTACT INFORMATION

Are confidential messages OK? Yes ___ No ___

HOME PHONE: ____________________ CELL PHONE: ____________________

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

## EMERGENCY CONTACT

NAME: _______________________________ PHONE:_______________________________

RELATIONSHIP: __________________________________

Thank you for allowing me to partner with you on your healing path. Please know that as your energies shift you may experience temporary physical or emotional discomfort. Feel free to reach out when you have questions or concerns. Practicing the self-care techniques between sessions will help you remain balanced between sessions and can deepen the hands-on work that we do. ~Stacy

By signing this form, you consent to receive Intuitive Energy Medicine sessions and understand that it is not a substitute for medical or psychological care. You agree to bring up any questions or concerns as they arise and keep communication open.

Signature________________________________ Date_______________

What is your primary reason for seeking energy medicine treatment?

What goals to you have for your health and wellbeing? Are you willing to do self-care and be a partner in your healing process?

Have you had energy work previously?

Do you suffer from:

Stress ________________________________

Blood Pressure _________________________

Auto-immune___________________________

Diabetes_______________________________

Hormonal Issues_________________________

Heart Disease___________________________

Mental Health____________________________

Cancer_________________________________

Allergies________________________________

Asthma_________________________________

Headaches______________________________

Other__________________________________

Surgeries? Dates and Outcomes

Describe any major accidents or traumatic events and approximate dates:

Any other concerns?