TELL ME ABOUT YOURSELF

Client Name _____ Phone _____

Address _____

City/State/Zip _____

Email _____

Date of Birth _____ Age _____ Height _____ Weight _____

Gender _____ Marital Status _____ # of Children ____

Emergency Contact _____ Phone _____

Medical Info
☐ Pacemaker ☐ Metal Plates / Screws ☐ Diabetes
☐ Organ Transplants ☐ Taking Immune Suppressant Drugs?
☐ Pain Pump ☐ Shunt ☐ Pregnant

Any childhood illnesses? _____

Any significant childhood trauma? _____

Any significant adult trauma? _____

Any allergies? _____

Any food sensitivities? _____

Any serious illnesses or hospitalizations? _____

TELL ME ABOUT YOURSELF

Any broken bones, surgeries, injuries, or accidents (add age and outcome)

_____

_____

Family History: select any that apply

☐ Alcoholism	☐ Diabetes	☐ High Blood Pressure	☐ Tuberculosis
☐ Allergies	☐ Drug Problems	☐ Kidney Disease	☐ Ulcers
☐ Arthritis	☐ Epilepsy	☐ Mental Disorders	☐
☐ Asthma	☐ Glaucoma	☐ Scoliosis	☐
☐ Cancer	☐ Heart Disease	☐ Stroke	☐

Current Medications	Purpose	Dosage/ Frequency	Taken for how long?	Adverse reactions?

Current Supplements	Purpose	Dosage/ Frequency	Taken for how long?	Adverse reactions?

PLEASE CIRCLE:	What kind?	How Often?
Alcohol		
Caffeine / Coffee		
Soda		
Tobacco		
Other Drugs		

TELL ME ABOUT YOURSELF

Primary / Secondary Concerns: please list all major concerns (and any accompanying symptoms) in order of importance. If you have received a medical diagnosis for your complaints, please list and provide date of diagnosis. Please specify when this concern began, cause, location, frequency, duration, and intensity (1-10 scale). Describe any factors that aggravate these concerns (e.g. weather, time of day, activity).

Any therapies or interventions that have worked or have not?

What gives you joy?

How do you relax?

TELL ME ABOUT YOURSELF

Review of Symptoms and Conditions

EYES	☐ Blurry ☐ Dry ☐ Floaters ☐ Grit ☐ Itchy ☐ Red ☐ Watery ☐ Cataracts ☐ Color Blind ☐ Contacts/Glasses ☐ Farsighted ☐ Nearsighted ☐ Glaucoma ☐ Eye Strain ☐ Night Blindness ☐ Pain/Pressure ☐ Double Vision ☐ Sensitive to Light
EARS	☐ Earaches ☐ Hearing Aids ☐ Loss of Hearing ☐ Ringing ☐ Sensitivity to Sound ☐ Vertigo
NOSE	☐ Frequent Colds ☐ Congestion ☐ Dry ☐ Stuffy ☐ Loss of Smell ☐ Nosebleeds ☐ Sinus Pain ☐ Polyps ☐ Deviated Septum ☐ Post-Nasal Drip ☐ Runny Discharge ☐ Allergies
THROAT	☐ Difficulty Swallowing ☐ Dry Throat/Mouth ☐ Excess Saliva ☐ Hoarse Voice ☐ Itchy ☐ Sore ☐ Ulcers ☐ Strep ☐ Swollen Glands
TEETH	☐ Cavities ☐Loose ☐ Sensitive ☐ TMJ Pain
GUMS	☐ Bleeding ☐ Gingivitis ☐ Receding ☐ Sores/Ulcers ☐ Tender
SKIN	☐ Acne ☐ Boils ☐ Bruises easily ☐ Clammy ☐ Dry ☐ Eczema ☐ Fungal Infections ☐ Itching ☐ Psoriasis ☐ Rashes / Hives ☐ Scars ☐ Sensitive ☐ Moles / Lumps ☐ Other: _____
PERPIRATION	☐ Spontaneous ☐ Excessive ☐ Rarely ☐ Nighttime ☐ Cold Sweats ☐ Unusual odor ☐ Other: _____
TEMPERATURE	☐ Too hot ☐ Too cold ☐ Cold hands / feet ☐ Chills / Fever ☐ Normal
CIRCULATION	☐ Blood clots ☐ Poor ☐ Edema ☐ Swollen Ankles ☐ Varicose veins
SLEEP	☐ Drowsiness ☐ Trouble Waking ☐ Trouble Falling Asleep ☐ Waking at Night ☐ Trouble Going Back to Sleep ☐ Restless Sleep ☐ Light Sleeper ☐ Deep Sleeper ☐ Excessive Dreams ☐ Nightmares Hours per night: _____ Time to bed: _____ Time to wake: _____
RESPIRATION	☐ Asthma ☐ Bronchitis ☐ Cough ☐ Blood/Phlegm ☐ Emphysema ☐ Pneumonia ☐ Shortness of Breath ☐ Tuberculosis ☐ Wheezing
CARDIOVASCULAR	☐ Arteriosclerosis ☐ Chest Pain ☐ Coronary Disease ☐ Heart Murmur ☐ Heaviness or Tightness in Chest ☐ High Blood Pressure ☐ High Cholesterol ☐ Low Blood Pressure ☐ Hypertension ☐ Hypotension ☐ Congenital Heart Defects ☐ Palpitations ☐ Irregular heart beat ☐ Pacemaker ☐ Stints ☐ Stroke ☐ Heart Attack ☐ Edema ☐ Varicose Veins ☐ Other: _____
MISCELLANEOUS	☐ Hypothyroid ☐ Hyperthyroid ☐ Diabetes ☐ HIV ☐ Cancer

TELL ME ABOUT YOURSELF

Dietary History and Nutrition

APPETITE	☐ None ☐ Weak ☐ Normal ☐ Strong ☐ Irregular
FOOD AFFECTS YOU	☐ Energized, Satisfied ☐ Unsatisfied ☐ Fatigue, Sleepy
TASTE PREFERENCE	☐ Sweet ☐ Sour ☐ Salty ☐ Pungent ☐ Bitter ☐ Astringent
DIGESTIVE	☐ Bloating ☐ Pain ☐ Acid Reflux ☐ No Appetite ☐ Bad Breath ☐ Belching ☐ Candida ☐ Eating Disorder ☐ Food Allergies ☐ Gas ☐ Heartburn ☐ Hiccups ☐ Hypoglycemia ☐ Nausea ☐ Nutritional Deficiencies ☐ Ulcers ☐ Weight Issues ☐ Vomiting
GASTROINTESTINAL	Frequency of Stools: _____ /day Consistency of Stools: ☐ Normal ☐ Hard ☐ Loose ☐ Alternating ☐ Constipation ☐ Diarrhea ☐ Laxative Use ☐ Undigested Food in Stool ☐ Bloody Stool ☐ Anal itching / burning ☐ Colitis ☐ Crohn's Disease ☐ Gallstones ☐ Hemorrhoids ☐ Intestinal Pain / Cramping ☐ Irritable Bowel Syndrome ☐ Parasites ☐ Liver Disease ☐ Hepatitis
YOUR DIET	☐ Vegetarian ☐ Vegan ☐ Animal Protein ☐ Raw Foods ☐ Low Fat ☐ Processed Foods ☐ Fast Foods ☐ Microwaved Foods
CRAVINGS?	
FOODS YOU AVOID?	
FOOD ALLERGIES?	

Women Only:

PREGNANCY	☐ Currently Pregnant # of Pregnancies _____ # of Abortions _____ # of Childbirths _____ # of Miscarriages _____
MENSTRUAL	Started Age: _____ Date of Last: _____ Day Cycle: _____ ☐ Irregular ☐ Painful ☐ Clots ☐ Heavy ☐ Spotting ☐ Cramps ☐ No Period / Skipped Cycles PMS Signs/Symptoms: ☐ Acne ☐ Fatigue ☐ Bloating ☐ Diarrhea ☐ Headache ☐ Irratable ☐ Breast Tenderness ☐ Constipation ☐ Water Retention ☐ Low Back Pain ☐ Mood Changes ☐ Food Cravings
OTHER	☐ Cancers ☐ Cysts ☐ Uterine Fibroids ☐ Fibrocystic Breasts / Lumps ☐ Herpes: Oral / Genital ☐ Hysterectomy ☐ Painful Ovulation ☐ Pelvic Inflammatory Disease ☐ Sexually Transmitted Diseases ☐ Infertility ☐ Other _____

Men Only:

☐ Impotence ☐ Premature Ejaculation ☐ Genital Pain ☐ Sexually Transmitted Diseases
☐ Seminal Emission ☐ Prostate Problems ☐ Other: _____

TELL ME ABOUT YOURSELF

Neurological & Emotional Health

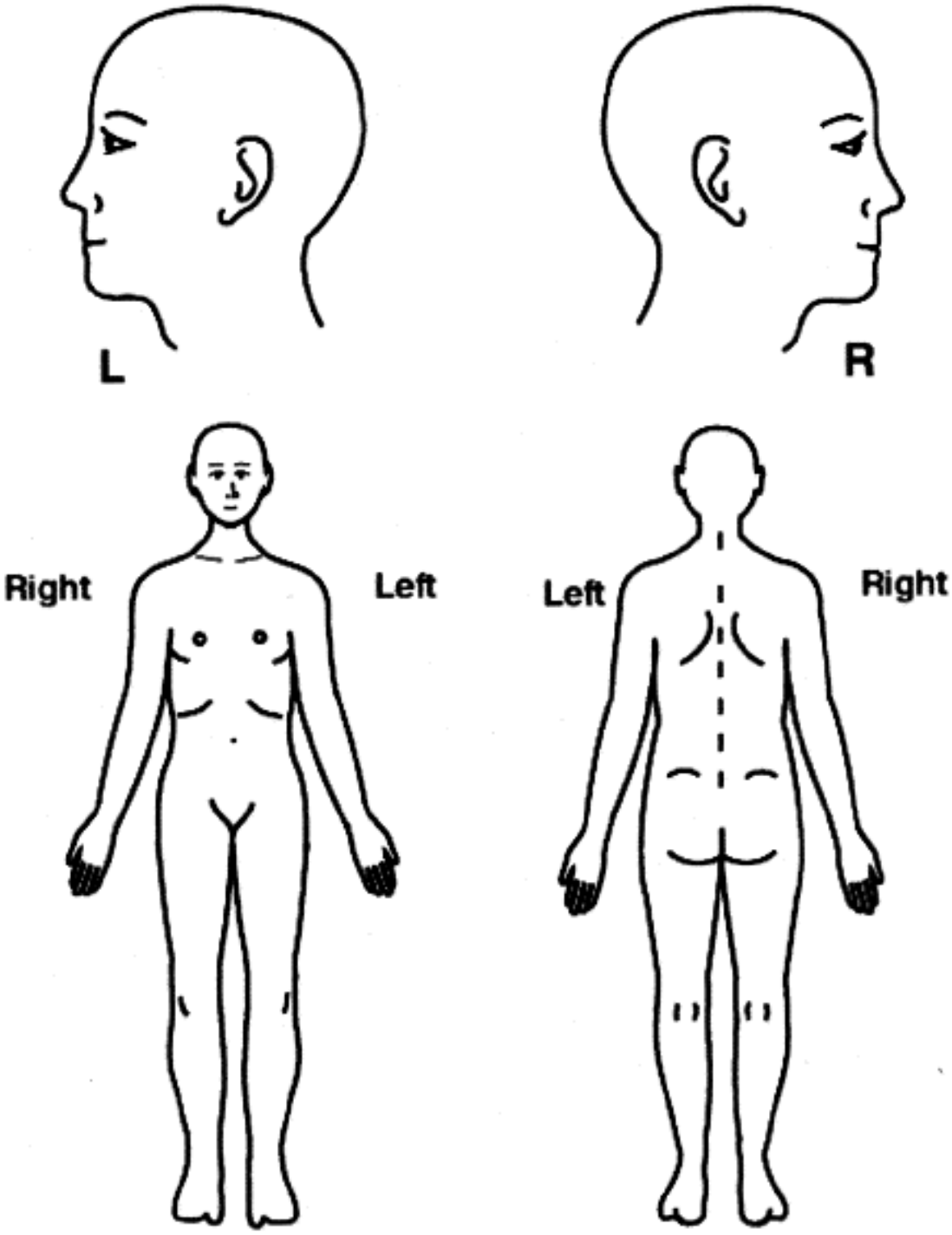
☐ Anxiety	☐ Poor Memory	☐ Anger/Rage/Aggressive
☐ Nervous	☐ Poor Concentration	☐ Impatient
☐ Fearful	☐ Trouble Making Decisions	☐ Easily Frustrated
☐ Insecure	☐ Suppress/Deny Emotions	☐ Irritable
☐ Lonely	☐ Trouble Letting Go	☐ Critical/Judgmental
☐ Mood Swings	☐ Grief/Sadness	☐ Vertigo/Dizziness
☐ Hysterical / Excitable	☐ Attached/Possessive	☐ Seizures/Epilepsy
☐ Impulsive / Erratic	☐ Depression	☐ Multiple Sclerosis
☐ Ungrounded	☐ Forgetful	☐ Parkinsons/Tremors
☐ Active, Restless Mind	☐ Current Psychotherapy	☐ Paralysis/Numbness
☐ Emotionally Sensitive	☐ Past Psychotherapy	☐ Loss of Balance
☐ Confused, Uncertain	☐ Suicide Attempt	☐

Pain

MUSCULOSKELTAL	☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower Back
JOINT PAIN / SWELLING	☐ Shoulder ☐ Elbows ☐ Wrists ☐ Hands ☐ Hips ☐ Knees ☐ Ankles ☐ Feet ☐ Cracking of Joints
HEADACHES	Frequency: _____ Location: ☐ Forehead ☐ Temples ☐ Back of Head ☐ Top of Head ☐ Entire Head ☐ Left Side ☐ Right Side ☐ Behind Eyes ☐ Sinuses
ACCOMPANYING SYMPTOMS	☐ Nausea / Vomiting ☐ Poor Mental Functions ☐ Dizziness ☐ Other _____
OTHER CONDITIONS	☐ Arthritis ☐ Bursitis ☐ Carpal Tunnel Syndrome ☐ Fibromyalgia ☐ Gout ☐ Numbness / Tingling ☐ Osteoporosis ☐ Sciatica ☐ Pinched Nerve ☐ Tendonitis
LEVEL OF PAIN	(mild) 1 2 3 4 5 6 7 8 9 10 (severe)
DURATION	☐ Constant / Steady ☐ Periodic / Intermittent ☐ Other: _____
PAIN BETTER WITH	☐ Pressure ☐ Heat ☐ Cold ☐ Movement ☐ Rest ☐ Lying Down ☐ Sitting ☐ Food ☐ Massage ☐ Medications
PAIN WORSE WITH	☐ Pressure ☐ Heat ☐ Cold ☐ Movement ☐ Rest ☐ Lying Down ☐ Sitting ☐ Food ☐ Massage ☐ Medications
IMPACT ON LIFE?	
OTHER SYMPTOMS?	

TELL ME ABOUT YOURSELF

Mark Areas of Pain with an X



TELL ME ABOUT YOURSELF

What do you hope to gain from your Energy Medicine Sessions?

Anything else I should know?

PLEASE READ CAREFULLY

I understand that the 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 understand that Energy Medicine is not as substitute for medical attention or for the diagnosis and/or treatment of medical or mental health conditions by a licensed health care professional. Although Energy Medicine uses the term "medicine," it does not imply that Energy Medicine practitioners are practicing medicine. Energy Medicine practitioners do NOT diagnose, treat, or prescribe for medical conditions. If you have a disorder that has been or SHOULD be diagnosed or evaluated by a licensed medical or mental health professional, my services should be used only in conjunction with your obtaining that care.

Energy Medicine attempts to optimize the body's overall health and vitality, bringing about your body's ability to physically improve itself by impacting the electromagnetic fields that regulate the body as well as by shifting more subtle energies typically described in non-Western cultures with terms such as chakras, meridians, and etheric fields.

SIGNATURE _____ **DATE** _____