

**CLIENT INTAKE FORM**

## Please update me on any changes in your contact information!

##

 NAME

ADDRESS CITY/PROVINCE

BIRTH DATE

OCCUPATION

HOME PHONE CELL PHONE EMAIL ADDRESS EMERGENCY CONTACT

PHONE RELATIONSHIP

Are confidential messages OK? Yes No

PLEASE READ CAREFULLY:

I understand that the Eden 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.

Where appropriate, energy practitioners can complement orthodox medicine, with the approval of the individual's GP or consultant. Depending on the nature of your medical condition and treatment, you may be asked to obtain written permission from your doctor prior to treatment commencing

*I further understand that E EM should not be construed as a substitute for needed medical attention. ENERGY M E DICIN E practitioners do not diagnose, treat, or prescribe for medical conditions. Energy Medicine 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 field s.*

*SIGNATURE: DATE:*

# What do you hope to gain from your Energy Medicine sessions?

Describe problems you wish to address. Include how long you have had them, any medical diagnosis for them, treatments you have tried, and their effectiveness:

Do you have a Pacemaker? Do you have Metal Plates or Screws in your body?

Do you have Diabetes? Are you pregnant?

FAMILY MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma

Allergies Other Significant Illnesses:

YOUR MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma

Allergies: Other Significant Illnesses

Surgeries (and dates):

# Have you ever been diagnosed or been treated for psychiatric conditions?

# Have you ever taken medication or drugs to help you with emotional or psychological problems?

# Do you have a family history of mental illness or substance abuse?

# Do you or someone in your family have a history of severe depression or anxiety, bipolar disorder, dissociative conditions such as multiple personality, dissociative identity disorders, or personality conditions such as borderline personality disorder?

# Describe any major accidents or traumatic events, including physical or sexual abuse, and

# approximate dates: