Deborah Mackay

Body Energies

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**CLIENT INTAKE FORM**

***Please update me on any changes in your contact information!*** DATE:

# NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY/STATE/ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION:** Are confidential messages OK? Yes\_\_\_\_\_ No\_\_\_\_\_\_

HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:

**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.

## I further understand that EEM should not be construed as a substitute for needed medical attention. ENERGY MEDICINE 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 fields.

## 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** | **Dates** |
|  |  |
|  |  |
|  |  |

**Describe any major accidents or traumatic events and approx. dates:**

**Allergies (drugs, chemicals, foods, airborne allergies, etc.)**

**Current Medications:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Purpose** | **Dosage / Frequency** | **Taken for how long** | **Any adverse reactions?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Current Nutritional And Herbal Supplements** (use back if necessary):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Purpose** | **Dosage / Frequency** | **Taken for how long** | | **Any adverse reactions?** |
|  |  |  |  | |  |
|  |  |  |  | |  |
|  |  |  |  | |  |
| **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**

**ARE THERE ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS?**