LymphWorks, LLC- The BodyWork Experts

Distance or Energy Healing Session Intake Form

Full Legal Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Daytime phone:_____ Evening phone:_____

Date of Birth:_____ Age:_____ Gender: □ M □ F Marital Status:_____

Occupation:_____ Hours per week:_____

Employer:_____ Email Address: _____

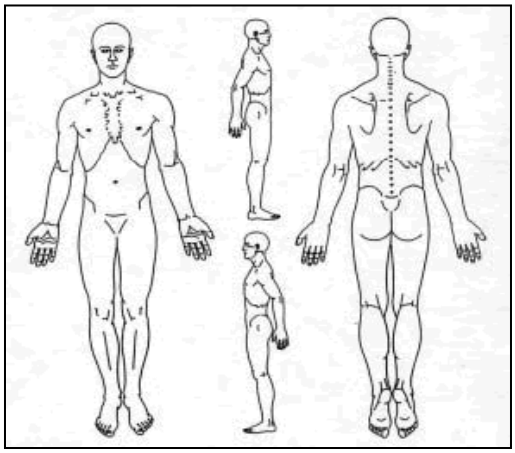
Emergency Contact:_____ Phone:_____ Relationship:_____

Referred by (so I can thank them!) or how you heard about me:_____

If receiving Distance Healing, what is your preferred method of payment? (Credit over phone or paypal)

Why are you here today? What is your presenting complaint?

Current Social Support / Living Situation/Significant Relations? (Family, alone, pets, children, etc):



Major Medical: Please list all significant illnesses, accidents, and traumas Experienced in your life (physical, mental, emotional, spiritual). Mark if chronic -→

1)_____ Date:_____

2)_____ Date:_____

3)_____ Date:_____

4)_____ Date:_____

5)_____ Date:_____

6)_____ Date:_____

Current Medications and supplements:

1)_____ reason:_____ 7)_____ reason:_____

2)_____ reason:_____ 8)_____ reason:_____

3)_____ reason:_____ 9)_____ reason:_____

4)_____ reason:_____ 10)_____ reason:_____

5)_____ reason:_____ 11)_____ reason:_____

6)_____ reason:_____ 12)_____ reason:_____

Do you use? Type/Frequency Alcohol Recreational Drugs Tobacco Caffeine

Describe your Nutrition / Diet (vegetarian, carnivore, red meat etc):

Digestion /Elimination (regular, constipated often, diarrhea often, MTHFR problems, other):

Menstrual Cycle (normal, heavy, irregular, menopausal, other):

Water Intake: Glasses per day_____ **Sleep Patterns:** Normal? Insomnia? Use of Aides?

Family History (birth? where/how grew up? parents together? siblings?):

Significant Past / Current relationships?

Regular Health Care: Do you visit any other health practitioners on a regular basis? **Yes** **No**

Doctor, Chiropractor, PT, Counselor, Acupuncturist, Naturopath, Other? Please share names and frequency:_____

_____

_____

_____

Current Personal Stress Scales (0 no stress, 10 extreme stress)

From: Illness_____ Work_____Relationships_____Finances_____Loss_____Other_____ Why?

Relaxation / Self Care (circle/describe all that apply): **Exercise/Sports, Hobbies, Friends, Support Groups, Other**

What, if any, spiritual practices or beliefs do you have?

What do you believe is the reason for your current health issues?

www.FortCollinsLymph-Massage.com ~ (970) 222-9421

Consent form for Advanced Energy Healing and Medical Intuitive Session

By signing below, I hereby represent and agree as follows:

- I promise to carefully read this form before and after the energy healing session and reading.
- I am over 18 years of age; or, I am the parent or legal guardian of the subject of the reading / healing session.
- I wish to obtain Energy Healing Session and/or Educational Intuitive reading.
- **I am currently under the care of a physician or other health care practitioner.** I understand that no physician-patient relationship is established through my participation in this session/reading. I understand this session/reading is not psychotherapy.
- During this educational consultation, a list of available options or solutions will be described, but **I agree that before undertaking any of these options or solutions, I will consult my physician or other health care practitioner whose care I am currently under.**
- I acknowledge by signing this form I have not been **hospitalized for psychiatric reasons** within the last three (3) years.
- I understand that therapist Carol J. McDaniel is a Licensed Massage Therapist in the state of Colorado, a Healing Touch Certified Practitioner, a Certified Reiki Master Practitioner, and a McKay Method® Graduate.
- I understand that Carol J. McDaniel reserves the right to refuse to do a session / reading or to end one at any time and will refund the client's payment in full.
- I understand that Energy Healing and Medical Educational Intuitive Reading is not medical diagnosis, medical treatment, or medical advice; therefore I understand that Energy Healing and Medical Educational Intuitive Consultation **will not provide prescription, treatment or psychotherapy.**
- I understand that Energy Healing and Medical Educational Intuitive Reading are not reimbursable by insurance.
- **This session is not meant to replace treatment by established medical practices but to complement them.**
- All issues related to my session/s will be kept in confidence per the law.
- **CANCELLATION POLICY:** No refund will be given if we receive notice of your cancellation less than 24 hours from your scheduled appointment time.

Signature_____**Date**_____

Name (please print)_____

Address:_____ **State:** _____ **Zip Code:** _____

Email_____ ☑ **Website and/or brochure given to client**