Blue Lotus Healing Arts
Energy Medicine & Creative Therapeutic Bodywellness

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# CLIENT INTAKE FORM

NAME _____ DATE _____

EMAIL _____ Birth Date _____

ADDRESS_____

CITY/STATE/ZIP_____

OCCUPATION_____ Referred by_____

CONTACT INFORMATION: Are confidential messages ok? Yes___ No___

Preferred Method: VOICE_____ TEXT_____EMAIL_____

HOME PHONE_____ CELL PHONE_____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP_____ PHONE_____

**PLEASE READ CAREFULLY:**

I understand that the Eden Energy Medicine sessions I receive are provided for the basic purpose of balancing and harmonizing my body's energies. As with all sessions I receive – whether it be harmonic massage, vibrational raindrop, sound massage – if I experience any pain or discomfort during a session, I will immediately inform my practitioner during the session.

*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 may address physical concerns by working with 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 (auric) fields.*

**SIGNATURE**_____ **DATE**_____

All answers on this form are confidential. Please list the name(s) and specialties of other health care professionals you are currently seeing and approximate date of your last physical exam *on the back*.

Do you have a pacemaker? _____ Do you have any bionic parts (replacements)? _____

Do you have metal plates or screws in your body?_____ If so, where_____

Please circle below if you currently have any of the following conditions:

Diabetes Cancer Seizures Asthma

Heart Disease High Blood Pressure or Hypertension

Allergies (Drugs, chemicals, foods, airborne, etc)_____

_____

Other Significant Illnesses or Treatment_____

| SURGERIES | MAJOR ACCIDENTS/INJURIES | DATES |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Current Medications, or Nutritional and Herbal Supplements:

| Name | Purpose | Dosage/Frequency | How long taken | Adverse reactions |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Please note if use: | Y/N | What Kind? | How often? Per day/per week |
|---|---|---|---|
| Alcohol | | | |
| Caffeine/Coffee/Tea | | | |
| Soda | | | |
| Tobacco | | | |
| Marijuana | | | |
| Over the counter meds | | | |
| Amphetamines | | | |
| Cocaine | | | |
| Other | | | |

NOTE: If substance-use appears to be *life threatening*, I am required by law to take appropriate action.

Describe the main reason for your visit, and any other problem(s) you wish to address. Please include how long they have been happening, any medical diagnosis for them, treatments you have tried, and their effectiveness.

What gives you Joy?

How do you deal with stress?

How do you relax?

How do you care for your body, emotions and spirit?

Where / how did you find me?

| | | |
|---|---|---|
| Referral (who?) | ☐ | _____ |
| Google | ☐ | _____ |
| Social Media | ☐ | _____ |
| Yoga Class | ☐ | _____ |
| Other (specify) | ☐ | _____ |