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_____

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. 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:

Do you have a pacemaker? _____ Do you have metal plates or screws in your body?_____ If so, where_____ Do you have an bionic parts (replacements)?

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

Diabetes Cancer High Blood Pressure or Hypertension Heart Disease
Seizures Asthma

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

Other Significant Illnesses or Treatment_____

SURGERIES	MAJOR ACCIDENTS/INJURIES	DATES

Current Medications, or Nutritional and Herbal Supplements:

Name	Purpose	Dosage/Frequency	Taken for how long	Adverse reactions?

Please circle if use:	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?