

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)


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