Center For Energy Healing
Creating a Balance Within

(908) 249-1061
centerforenergyhealingnj@gmail.com
www.centerforenergyhealing.com

Client Intake Form

Date _____ /_____ /_____

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: (Home) _____ (Mobile) _____

Emergency Contact: _____ Relation: _____

Phone: (Home) _____ (Mobile) _____

Primary Care Physician: _____ ❑ Consent to Contact Physician Phone: _____

To Be Filled Out By Practitioner

SPO2: _____ /_____

Blood Pressure: _____

Pulse: _____

What can we help you with today? _____

_____

Are you experiencing pain? ❑ Yes ❑ No If yes, please explain where and for how long: _____

_____

Please share a little about yourself. What do you do for a living? If retired, what type of work did you do? _____

_____

On a scale of 1-10, what is your stress level on most days? _____ What do you do to manage stress? _____

_____

Please describe yourself emotionally? _____

How many hours of sleep do you get every night? _____ How do you feel when you wake up? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how often and what type? _____

Do you smoke? ❑ Cigarettes ❑ Marijuana If yes, how much? _____

Do you exercise? ❑ Yes ❑ No If yes, what do you do and how often? _____

Do you take vitamins/supplements? _____

Do you skip meals? _____

Do you have any allergies? If yes, please list: _____

_____

Do you experience small memory losses? ❑ Yes ❑ No

Did you suffer any trauma before the age of 10? ❑ Yes ❑ No If yes, please explain: _____

Have you been a car accident? _____

Have you ever been diagnosed with cancer? ❑ Yes ❑ No If yes, are you still receiving treatment? _____

Have you ever had surgery? ❑ Yes ❑ No If yes, please explain what type? _____

Have you tried other methods of alternative therapy? ❑ Energy Work ❑ Meditation/Guided Imagery ❑ Acupuncture ❑ Massage

❑ Other: _____

ANF Requires a follow-up appointment three (3-4) days after the first treatment to reassess.
We recommend routine appointments thereafter to monitor progress.

Continued on back

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Client Intake Form (continued)

These discs do not contain medicine and therefore will not interfere with any current treatment, aside from chemotherapy or radiation. There are no side effects aside from possible detoxification symptoms which include tiredness, lack of energy, headache, dry mouth, lightheadedness, dizziness, mild flu symptoms, runny nose, skin conditions, and general malaise. The client will be made aware of these possible symptoms, which are a result from the treatment and will be advised to drink more water in order to lessen them.

- I understand and consent to this treatment for my specific condition(s). I undertake this therapy willingly and agree to follow my practitioner's advise in order to restore healthy bodily function.
- I understand that adequate water intake is essential to this therapy and I agree to follow my practitioner's recommendations to obtain optimal benefits.
- Furthermore, I understand that I will begin this treatment of my own free will and can stop at any time without explanation. I realize that should I choose to terminate therapy prior to the normalization of my physical dysfunction(s), my symptoms or conditions may return.
- **Medical Disclaimer:** I will keep my therapist informed about any changes in my health.

❏ I have filled out this questionnaire to the best of my ability.

❏ Print Client Name: _____ ❏ Print Guardian Name: _____

Authorized Signature ❏ Client ❏ Guardian: _____ Date: _____

An Authorized Signature from a Parent/Guardian is required for anyone under the age of 18.

The information/services provided in wiriting or on the website is intended for educational purposes only and should not be considered a substitute for professional medical advice, dx, or treatment. Results are individual. Specific outcomes are not guaranteed.

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Health History

Date _____ /_____ /_____

Please check the following conditions that apply to you, whether past or present.

Musculoskeletal

- ❍ Headaches
- ❍ Joint stiffness
- ❍ Spasms/ cramps
- ❍ Broken bones
- ❍ Sprains
- ❍ Back/ hip pain
- ❍ Shoulder /neck pain
- ❍ Arm/ hand pain
- ❍ Leg/foot pain
- ❍ Chest/ abdominal pain
- ❍ Jaw pain/TMJD
- ❍ Tendinitis
- ❍ Bursitis
- ❍ Osteoarthritis
- ❍ Rheumatoid arthritis
- ❍ Scoliosis
- ❍ Bone or joint disease
- ❍ Trouble walking

Circulatory and Respiratory

- ❍ Dizziness
- ❍ Shortness of breath
- ❍ COPD
- ❍ Fainting
- ❍ Cold hands/ feet
- ❍ Swollen ankles
- ❍ Blood clots
- ❍ Heart failure
- ❍ Heart attack
- ❍ Sinus issues
- ❍ Asthma
- ❍ Seasonal allergies
- ❍ High blood pressure
- ❍ Low blood pressure
- ❍ Varicose veins
- ❍ Lymphedema

Skin

- ❍ Rashes
- ❍ Allergies
- ❍ Fungal infection
- ❍ Ulcers
- ❍ Warts
- ❍ Moles
- ❍ Acne
- ❍ Cosmetic surgery
- ❍ Chemical sensitivity

Digestive

- ❍ Nervous stomach
- ❍ Loss of appetite
- ❍ Hiatal hernia
- ❍ Constipation
- ❍ Diarrhea syndrome
- ❍ Fecal incontinence
- ❍ Urinary incontinence
- ❍ Diverticulitis
- ❍ Irritable bowel
- ❍ Ostomy devices
- ❍ Crohn's disease
- ❍ Colitis
- ❍ Ulcers
- ❍ Urinary tract infections

Reproductive System

- ❍ Current pregnancy
- ❍ Menopause
- ❍ Pelvic inflammatory disease
- ❍ Endometriosis
- ❍ Hysterectomy
- ❍ Benign prostatic hypertrophy
- ❍ Impotence
- ❍ Hormone replacement

Nervous system

- ❍ Numbness/ tingling
- ❍ Migraines
- ❍ Chronic pain
- ❍ Stroke
- ❍ Fibromyalgia
- ❍ Paralysis
- ❍ Epilepsy
- ❍ MS/MD /Parkinsons
- ❍ Herpes/ shingles
- ❍ Benign tremor
- ❍ Cerebral palsy
- ❍ Brain/ spine injury

Other

- ❍ Forgetfulness
- ❍ Depression
- ❍ Trouble concentrating
- ❍ Hearing impaired
- ❍ Visually impaired
- ❍ Diabetes
- ❍ Fibromyalgia
- ❍ Post-polio
- ❍ Cancer
- ❍ Hepatitis C
- ❍ Infectious diseases
- ❍ Liver disease
- ❍ AIDS/ HIV+
- ❍ Kidney disease

Other: _____