



**FIVE RHYTHMS
CONSULTING**

CLIENT INTAKE FORM

Please update me on any changes in your contact information!

DATE: _____

1. NAME: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ SOCIAL SECURITY #: _____

OCCUPATION: _____

REFERRED BY: _____

CONTACT INFORMATION

Are confidential messages OK? Yes ___ No ___ (Please indicate if confidential messages should not be left at any of these)

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ e-ADDRESS: _____

EMERGENCY CONTACT

NAME: _____

PHONE(S): _____

RELATIONSHIP: _____

PLEASE LIST THE NAME and specialties of other health care professionals you are currently seeing, as well as the name of your primary physician and approximate date of your last physical exam:

PLEASE READ CAREFULLY

I understand that the Energy Medicine and/or Energy Psychology sessions I receive are provided for the basic purpose of harmonizing my body's energies. If I experience any pain or discomfort during a session, I will immediately inform my practitioner.

I further understand that Energy Medicine and/or Energy Psychology should not be construed as a substitute for needed medical attention. Energy Medicine and/or Energy Psychology practitioners do not diagnose, treat, or prescribe for medical conditions. Energy Medicine and/or Energy Psychology bring about physical improvements by impacting 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 fields.

SIGNATURE: _____ DATE: _____

What do you hope to gain from your Energy Medicine and/or Energy Psychology sessions?

Describe problems you wish to address. Include how long you have had them, any medical or psychological diagnosis for them, treatments you have tried, and their effectiveness:

Do you have a Pacemaker? _____
Do you have Metal Plates or Screws in your body? _____
Do you have Diabetes? _____
Are you pregnant? _____

FAMILY MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures
Asthma Allergies Mental Illness Other Significant Illnesses (please list):

YOUR MEDICAL HISTORY (please circle)

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures
Asthma Allergies Mental Illness Other Significant Illnesses (please list on next page):

Surgeries	Dates

Describe any major accidents or traumatic events and approximate dates:

ALLERGIES (drugs, chemicals, foods, airborne allergies, etc.)

CURRENT MEDICATIONS

Name	Purpose	Dosage and Frequency	Taken for how long?	Any adverse reactions?

CURRENT NUTRITIONAL AND HERBAL SUPPLEMENTS (use back if necessary)

Name	Purpose	Dosage and Frequency	Taken for how long	Any adverse reactions?
PLEASE CIRCLE	What kind?	How often? Per day/per week		
Alcohol				
Caffeine/Coffee				
Soda				
Cigarettes/Tobacco				
Over-the-Counter Me				

All answers on this form are confidential. However; if substance-use appears to be *life threatening*, I am required by law to report it.

PLEASE CIRCLE THOSE THAT APPLY	Last used	Amount used	Frequency Per day/ per week	Any adverse reaction
Marijuana				
Amphetamines				
Cocaine				
Other				

What gives you joy?

How do you deal with stress?

How do you relax?

How do you take care of your body?

Are there any other issues you would like to discuss?

How did you hear about Five Rhythms Consulting?

May I thank them for referring you? Yes _____ No _____ What is their name? _____