FIVE RHYTHMS
CONSULTING

CLIENT INTAKE FORM

DATE: ____________________

NAME: _____________________________ EMAIL: ____________________

ADDRESS: ____

CITY:______________________________ STATE: ________ ZIP: ______________

BIRTH DATE: ________________

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: _______________________

Receive our bi-monthly e-Newsletter with tips, research updates and class information?
Yes___ No ____

EMERGENCY CONTACT

NAME: ____

PHONE(S): ____

RELATIONSHIP: _________________________________

9 Heard Road, Wayland, MA 01778
617-388-5079 www.Consultfr.com Contact@Consultfr.com

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: ______________________________

Name: _________________________________

Date: ______________

On behalf ___________________________________ (minor's first and last name)

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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

Asthma Allergies Mental Illness Seizures

Other Significant Illnesses (please list here):

Surgeries	**Dates**

Describe any major accidents or traumatic events and approximate dates:

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

CURRENT MEDICATIONS

Name	Purpose	How often and for how long?	Any adverse reactions?

CURRENT NUTRITIONAL AND HERBAL SUPPLEMENTS (use back if necessary)

Name	Purpose	How often and for how long	Any adverse reactions?
PLEASE CIRCLE			
Alcohol			
Caffeine/Coffee			
Soda			
Cigarettes/Tobacco			
Over-the-Counter Medications			

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? ___________________________________