



ENERGYGIRL, LLC

CLIENT INTAKE FORM

Please fill in the information below and bring it with you to your first session or email it back to Info@EnergyGirl2020.com. All information on this form is considered part of your confidential record.

PERSONAL INFORMATION

Name _____ Date _____

Parent/Guardian (if under 18) _____

Address _____

Cell Phone _____ Is texting or leaving a message permitted? Yes No

Home/Work Phone _____ Is leaving a message permitted? Yes No

Email address _____ Is leaving a message permitted? Yes No
(*****Please note that Email correspondence is *not* considered a confidential method of communication*****)

Date of Birth _____ Marital Status S M D W O

Occupation/Employer _____

How did you hear about EnergyGirl, LLC/Referred by? _____

Emergency Contact Name, Number & Relationship _____

PLEASE READ CAREFULLY

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

I further understand that Reiki/Energy healing should NOT be construed as a substitute for needed medical attention. Reiki/Energy healing practitioners do not diagnose, treat, or prescribe for medical conditions. Reiki/Energy healing brings 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 _____

MEDICAL HISTORY

Do you have a pacemaker? _____

Do you have metal plates or screws in your body? If yes, where? _____

Do you have any implantable devices (Tens unit, insulin pump, etc)? _____

Are you pregnant or might there be a chance you could be? _____

Please list all of your allergies and your reactions (Drugs, Chemicals, Foods, Environmental, etc) _____

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Your History

Family History

Diabetes	_____	_____
Cancer	_____	_____
Hypertension	_____	_____
Heart Disease	_____	_____
Stroke	_____	_____
Seizures	_____	_____
Autoimmune issues	_____	_____
Asthma	_____	_____
Migraines	_____	_____
Anxiety/Depression	_____	_____
Other Mental Illness Diagnoses	_____	_____
Major Surgeries and Hospitalizations	_____	

Please provide the name of your **Primary Physician** & phone number_____

List any **other healthcare specialists** you have seen in the past **10** years_____

Please list your **current medications** and **supplements** even if not taken every day_____

How often do you engage in **recreational drugs** (legal or otherwise)? Daily Weekly Monthly Never

How often do you drink **alcohol**? Drinks/day_____ Drinks/week_____ Never

Do you smoke **cigarettes**? _____ If you quit, when did you quit?_____

ADDITIONAL INFORMATION

Are you sensitive to **perfumes** or fragrances? Yes No

Are you sensitive to **touch**? Yes No

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How do you **take care** of your body? _____

What gives you **joy**? _____

How do you deal with **stress**? _____

How do you **relax**? _____

Do you consider yourself to be **spiritual or religious**? If yes, describe your faith or belief system _____

What do you consider to be some of your **strengths**? _____

What do you consider to be some of your **weaknesses**? _____

What do you **hope to gain** from your Reiki/Energy healing sessions? _____

EnergyGirl, LLC does not share your contact information with any third parties. Would you like to be emailed periodic newsletters and company updates? Yes No

FOR DISTANT SESSIONS ONLY: Do you have a reliable internet connection and access to Zoom? Y N

What **time zone** are you in? _____