



ENERGY MEDICINE INTAKE FORM

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Email: _____ Occupation: _____

Telephone Number- Home: _____ Work: _____

Mobile: _____

Emergency Contact- Name: _____ Phone: _____ Relation: _____

How did you hear about me: _____

Other Health Care Providers:

Name: _____ Profession: _____ Phone: _____

Name: _____ Profession: _____ Phone: _____

Name: _____ Profession: _____ Phone: _____

HEALTH INFORMATION

Please list your health concerns (physical, emotional, or psychological) in order of importance to you and the date of onset:

1. _____ Age: _____

2. _____ Age: _____

3. _____ Age: _____

4. _____ Age: _____

5. _____ Age: _____



Please list your most stressful life experiences (physical or psychological):

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____

MEDICAL HISTORY

Have you had any surgery in the past?

Yes ☐ No ☐

If so, please let us know what was done and when:

SURGERY

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

If you have had any x-rays, lab tests, or other diagnostic tests done in the past year, please explain:



Are you diabetic?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you under more stress than usual?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have problems sleeping?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have high blood pressure?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have allergy symptoms been a problem?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you been bothered by skin rashes or itching?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you get short of breath easily?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you had problems with asthma?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have digestion problems?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Please describe the emotional climate of your home:

Rate your stress level (10 = high)

1 2 3 4 5 6 7 8 9 10

In your everyday life, your present faith/spiritual practices are (10 = very important):

1 2 3 4 5 6 7 8 9 10

Please rate your level of motivation to affect change in your health (10 = motivated).

1 2 3 4 5 6 7 8 9 10

Is there anything else you would like to tell us about your current state of health?



FEE SCHEDULE (as of Nov 2023)

ENERGY MEDICINE – New Clients	
NEW CLIENT- INITIAL CONSULTATION BY DISTANCE (ADULTS OVER 18)	\$190.00
Includes: Consultation and Energy Balancing via zoom conferencing or email	
NEW CLIENT- INITIAL CONSULTATION BY DISTANCE (CHILD/YOUNG ADULT UNDER 18)	\$147.00
Includes: Consultation and Energy Balancing via zoom conferencing	
ENERGY MEDICINE – Returning Clients	
DISTANCE SESSION	\$85.00
Includes: Long Distance Energy Balancing - Appointments viz zoom conferencing or email	
EMERGENCY DISTANCE SESSION	\$90.00
Includes: Emergency Long Distance Energy Balancing - off business hours in emergency circumstances	
FAMILY PET SESSION	\$85.00
Includes: Distance Energy Balancing for Pets	
PAST LIFE REGRESSION	
Past Life Regression	\$285.00
Includes: 2 Hour Past Life Regression Session, Transcript and Recording	

* HST is included

* * Cancellation Policy: a \$50.00 fee for distance sessions and a \$90.00 fee for initial consultations will be charged, if the appointment was not cancelled at least 24 hours prior to the appointment time or if the appointment has been missed.

My signature ensures that I have been made aware of the costs involved and I accept full responsibility for payment.

Full Patient Name (Please Print)

Client Signature or Parent/Guardian Signature

Date



DECLARATION AND CONSENT TO HOLISTIC ENERGY BALANCING

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your Holistic Energy Practitioner immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to Energy Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms within the following 24 hours

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself when law requires it. I understand that I may look at my medical record at any time and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Holistic Energy Practitioner will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the Holistic Energy Practitioner to be able to anticipate and explain all risks and complications. I will rely on the Holistic Energy Practitioner to exercise judgement which they feel at that time is in my best interests, based on the facts then known.

I am aware that these techniques are not a medical treatment or a substitute for professional medical, naturopathic, chiropractic, psychological or psychiatric treatment.

I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification within 24 hours in which case no charge will be applied.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

- Any treatment or advice provided to me as a client is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future from another health care provider;
- I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario;
- No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another health care provider;
- The treatment and therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other health care provider.

I DECLARE that I am not an agent or representative of any organization, media outlet or company investigating alternative treatment modalities such as Medical Intuition and Holistic Energy Balancing.

I DECLARE that I have received a full and complete explanation of services and that I have read and agree with its contents.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, administrative fees as well as other applicable fees.

Full Patient Name (Please Print)

Client Signature or Parent/Guardian Signature

Date