Anann Yassin **Eden Energy Medicine Advanced Practitioner**

Craniosacral Therapist, Indian Head Massage Practitioner

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CLIENT INTAKE FORM *Date_________________*

(Please update me of changes to your contact information)

Name_________________________ Email_____________________

Address____

Birth date___________________

Occupation____

Referred by______________________________

Contact Information: Are confidential messages okay ? Yes_____ No _____

Home Phone _____________ Work Phone _______________

Cell Phone ______________ Email Address _______________

Emergency Contact :

Name ______________________ Phone_____________________

Relationship _________________

Please list the name and specialities of other health care professionals you are currently seeing, as well as the name of your primary doctor and the approximate date of your last physical exam.

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PLEASE READ CAREFULLY:

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

I further understand that Eden Energy Medicine should not be construed as a substitute for diagnosis or treatment by a licensed and qualified health practitioner. Eden Energy Medicine practitioners do not diagnose, treat or prescribe for medical conditions.

Energy medicine 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 ____________________

Please provide 24 hours notice if you need to cancel an appointment.
Except in cases of emergency the full session fee of $100 will be due.

What do you hope to gain from your Energy medicine sessions?

Describe problems you wish to address. Include how long you have had them, and any medical 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 any past conditions in your family

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

Asthma Allergies Other Significant Illnesses: ______________________________

YOUR MEDICAL HISTORY : Please circle any illnesses in the past or present

Diabetes   Cancer   High Blood Pressure   Heart Disease   Stroke   Seizures

Asthma   Allergies   Other Significant Illnesses: ______________________________

Surgeries	Dates

Describe any major accidents or traumatic events and approximate dates :

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Allergies (drugs, chemicals, foods, airborne allergies, etc.) ____________________

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Current Medications :

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

Current Nutritional and Herbal Supplements :

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

Please Circle	What kind ?	How often per day or week ?
Alcohol		

Caffeine/ Tea or Coffee		
Soda		
Cigarettes/ Tobacco		
Over the counter Medications		

All answers on this form are confidential. If substance abuse appears to be life threatening I am required by law to report it.

Please Circle	Last Used	Amount Used	Frequency	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 ? ____________________________

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