

# Energy is the Medicine

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## CLIENT INTAKE FORM

**Please update me on any changes in your contact information!**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

### CONTACT INFORMATION

Are confidential messages OK? Yes \_\_\_ No \_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ e-Mail: \_\_\_\_\_

Please indicate if confidential messages should not be left at any of these

### 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 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 work should not be construed as a substitute for needed medical attention. Energy work practitioners do not diagnose, treat, or prescribe for medical conditions. Energy work 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: \_\_\_\_\_

What do you hope to gain from your energy sessions?

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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:

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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):

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**YOUR MEDICAL HISTORY** (please circle)

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

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SURGERIES	DATES

Describe any major accidents or traumatic events and approximate dates:

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ALLERGIES (drugs, chemicals, foods, air borne allergies, etc.)

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**CURRENT MEDICATIONS**

NAME	PURPOSE	DOSAGE AND FREQUENCY	TAKEN FOR HOW LONG	ANY ADVERSE REACTIONS?

**CURRENT NUTRITIONAL AND HERBAL SUPPLEMENTS** (request an additional sheet, if needed)

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 MEDICATIONS		

***All answers on this form are confidential.***

What gives you joy?

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How do you deal with stress?

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How do you relax?

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How do you take care of your body?

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Are there any other issues you would like to discuss?

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