Confidential Client Form

Personal Information

Name:_____ Date:_____

Birthdate:_____ Age:_____

Home Address:_____

City:_____ State:_____Zip/Postal Code:_____

Phone: Home/Work: _____ Cell:_____

email address:_____

Emergency Contact Details: Name: _____Number:_____

Relationship:_____

Place of Employment/Occupation:_____

Intentions

What is the reason for your visit today, what do you hope to achieve from this/these sessions?

_____

_____

Medical Information

Are you currently under a physician's care? ☐ yes ☐ no

If so, for what reason?

_____

Are you taking any medication? ☐ yes ☐ no

If yes please list name and purpose:_____

_____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better?_____

What makes it worse?_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

Abuse History	Eating disorders	Numbness
Accidents/Falls	Embolism	Orthodontics
Addictions	Emotional Problems	Osteoporosis
Allergies	Epilepsy	Seizures
Anger Issues	Feeling Heavy	PMS
Arthritis	Fibromyalgia	Sinus problems
Asthma	Grief	Spinal Pain
Birth Trauma	Headaches/Migraines	Spinal Surgery
Blood Clots	Heart Attack	Sprains or Strains
Broken Bones	Heart Disease	Stress
Bruise Easily	High/Low Blood Pressure	Stroke
Cancer	HIV	Thrombosis
Congenital Problems	Joint Replacement	Varicose Veins
Diabetes	Joint Pain/Swelling	Virus [in last 3 days]
Dizziness	Kidney Dysfunction	Weight Issues
Depression	Lupus	
Ear Problems	Neuropathy	

How long have you had this condition?_____ Is it getting worse? ☐ yes ☐ no

Previous Surgeries & Dates:

_____

_____

__

Are there any other health issues you want to discuss?

_____

_____

__

Client History

Current complaint/issue?

Are you pregnant?
Do you have a pacemaker, hearing aid, wear glasses or contact lenses?
What physical or psychological symptoms do you have at the moment?
Are you currently under strong professional or personal stress?
Do you have any physical weak spots that you tend to react to under stress?
What is the quality of your sleep?
What other complaints/issues do you have that you are accustomed to e.g. chronic pain/illness?
What surgery, illness, or accidents have occurred?
Have you had your tonsils or appendix removed ? If so when?
Are you being treated by a specialist other than a Family Doctor? If so why?

For Esogetic Colorpuncture Sessions

Childhood History

Which childhood illnesses or issues did you experience?
How was your mother's pregnancy?
How was your birth?
How was your parents relationship during your childhood?
What was your relationship with your mother like?
What was your relationship with your father like?
Do you have any siblings? What was your relationship with them like?
Were there others in childhood who were important to you?
Do you remember any childhood incidents?
Did you suffer any physical trauma?
Did you suffer psychological trauma?
How was your puberty?
What is your relationship with your parents and siblings today?
Do you have any children? How do you view your relationship with them?

Please carefully read the following and sign below

I understand that the purpose of this and future colour puncture/energy/body work is to provide relaxation and possible relief of stress and/or muscular tension. I have disclosed to the practitioner any condition that may be contraindicated. I further understand that the work I am about to receive is not a replacement for medical attention, diagnosis and treatment. I understand that the practitioner is not qualified to diagnose or prescribe medical treatment for any physical or mental disorder and that nothing said during the course of the session or afterwards should be construed as such. I confirm that I have disclosed conditions and have answered all questions honestly and completely to the best of my knowledge. I agree to keep the Practitioner updated with respect to my medical profile and understand that there shall be no liability on the Practitioner's part should I fail to do so. I fully understand and accept that the Practitioner or Client has full authority to terminate this treatment or treatment programme for any reason should it be necessary.

If you have a specific medical condition or symptoms, Cranial Sacral or Color Therapy may be contraindicated and a release from your Physician may be required before any service is provided. Cranial Sacral or Color Therapy will be given while the body is clothed or draped as necessary with no bodily contact with pubic or breast ares. Should it be necessary to use colour/acupressure points near those areas as part of the treatment the Client will be advised and will appropriately drape/cover her/himself.

Appointments: I agree to notify the Practitioner 24 hours in advance of any appointment change. Any appointment missed without prior 24 hour notice shall be billed at the session rate.

Signed_____ Print_____ Date_____