Regina Energy Medicine Therapist
POWERS
415-572-2065

Client Intake Form - STRICTLY CONFIDENTIAL

Name _____ Date _____

Address _____ Date of Birth/Age _____

_____ Height _____ Weight _____

Telephones: Home _____ Work _____ Cellular _____

Email address: _____

Person to Contact in Emergency _____ Phone _____

Relationship Status _____ Number of Children _____

Student-School _____ Grade _____

Current Doctor _____ Other Specialist _____

_____

Current Prescription Medications _____

_____

Current Complementary Therapies / Supplements _____

_____

Eating Habits / Diet _____

_____

Daily Intake: Water _____ Caffeine _____ Alcohol _____ Cigarettes _____

Normal Exercise Routine _____

Birth Experience (C-section,Vaginal,Breech) _____

*Mark the following areas of disease or symptoms. Use **C** = current, **P** = past or **R** = recurring. Explain if necessary.*

| **Emotional / Psychological** | **Endocrine** | **Cardiovascular** | **Reproductive** |
|---|---|---|---|
| Depression | Adrenal Insufficiency | Angina | Sexually-transmitted disease |
| Eating Disorder | Pituitary Dysfunction | Stroke | Endometriosis |
| Mood Swings | Hyperthyroid | Heart Attack | Miscarriage(s) |
| Substance Abuse | Hypothyroid | Hypertension | Abortion(s) |
| **Auto-Immune** | **Neurological** | **Respiratory** | **Other Issues (list)** |
| AIDS / HIV | Epilepsy | Bronchitis | |
| Allergies | Dizziness | Emphysema | |
| Cancer | Insomnia | Pneumonia | |
| Fatigue | Migraines | Tuberculosis | |
| Fever (severe) | Musculo-Skeletal | **Digestion** | |
| Fibromyalgia | Arthritis | Constipation | |
| Fungal Infections | Back Pain | Diabetes | |
| Herpes | Carpal Tunnel | Diarrhea (ongoing) | |
| Lyme Disease | Gout | Hepatitis | |
| Mononucleosis | Skin Disorder | Hypoglycemia | |
| **Urinary** | **Ear, Nose, Throat** | Jaundice | |
| Bladder infection | Earache | Ulcer | |
| Kidney Stones | Jaw Pain | Liver Disorder | |

## Injuries

List any injuries you have had, or currently have:

## Surgeries

List any surgical operations you have had, or know you will have:

## Trauma

List any traumatic or life-threatening events that occurred in your life, and when they happened:

## Expectations

What expectations do you have for this healing work - immediately and longer term?

## Other

Anything else you wish to mention?

Present Issue of Greatest Concern

**Rated Questions** (**10**Very happy **5** Okay **1** Not satisfied or happy in this area)

How do you feel about your Work situation? Or School?

**1 2 3 4 5 6 7 8 9 10**

How do you rate your current relationship? (Spouse, Parent, or home life?)

**1 2 3 4 5 6 7 8 9 10**

How do you rate your Emotional health?

**1 2 3 4 5 6 7 8 9 10**

How do you Feel about Yourself?

**1 2 3 4 5 6 7 8 9 10**

How do you rate you Physical health?

**1 2 3 4 5 6 7 8 9 10**

Please feel free to explain in more detail any of the above questions that have a rating 5 or below.

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