Heart of the Earth

Women's Healings

ABN 32 345 734 710

Client Intake Form

NAME: _____ AGE: _____

D.O.B _____ GENDER: _____ PHONE: _____

OCCUPATION: _____

EMAIL: _____

ADDRESS: _____

DO YOU CURRENTLY HAVE ANY COLD OR FLU SYMPTOMS? Y / N

HAVE YOU BEEN IN CLOSE CONTACT WITH ANYONE WHO HAS RECENTLY TESTED POSITIVE FOR COVID 19? Y / N

HAVE YOU HAD A HEALING OR TREATMENT OF THIS NATURE BEFORE? Y / N

WHAT ARE YOU HOPING TO GAIN FROM THIS SESSION OR FUTURE SESSIONS?

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? Y / N
IF ANSWERED YES, EXPLAIN WHAT FOR: _____

_____

DO YOU SMOKE? Y / N

ARE YOU, OR IS THERE A CHANCE YOU COULD BE PREGNANT? Y / N

ARE YOU MENSTRUATING? Y / N

IS YOUR CYCLE REGULAR? Y / N

ARE YOU TRYING TO CONCIEVE? Y / N

ANYTHING ELSE RELATING TO THIS ?

DO YOU HAVE, OR HAVE SUFFERED FROM ANY OF THE FOLLOWING? IF YES PLEASE EXPLAIN:

HEART PROBLEMS / PACE MAKER? _____

HYPERTENSION? _____

LOW BLOOD PRESSURE? _____

ASTHMA? _____

HEADACHE OR MIGRAINE? _____

STROKE? _____

NEUROLOGICAL CONDITION? _____

NERVE DAMAGE? _____

MS? _____

CANCER? _____

ARE YOU UNDER-GOING CHEMOTHERAPY? _____

DVT? _____

AIDS? _____

KIDNEY PROBLEMS? _____

FIBROMYALGIA? _____

EYE PROBLEMS? _____

OSTEOARTHRITIS? _____

RUEUMATOID ARTHRITIS? _____

BROKEN BONES? _____

THYROID CONDITION? _____

AUTO IMMUNE DISEASE? _____

ABDOMINAL PAIN? _____

IBD / IBS / OTHER? _____

ENDOMETRIOSIS? _____

BACK PAIN? _____

RECENT SURGERIES OR INJURIES? _____

BLOOD DISORDER? _____

SKIN CONDITIONS? (RASH, BURNS, FUNGAL, DERMATITIS, ACNE, INFECTIONS, BRUSING, CELLULITIS, WART VIRUS, SHINGLES, PSORIASIS, OTHER) _____

_____

CHRONIC FATIGUE? _____

INSOMNIA OR NIGHTMARES? _____

SLEEP APNEA? _____

VERTIGO? _____

ANXIETY DISORDER OR DEPRESSION / PND _____

CHRONIC STRESS / PTSD? _____

PSYCHOLOGICAL TRAUMA? _____

FAILING MEMORY / IMPAIRED DECISION MAKING / VAGUENESS / CONFUSION / FEELINGS OF PARANOIA / LACK OF FOCUS / HALLUCINATIONS? _____

ADHD / ASD / OTHER? _____

_____

_____

I UNDERSTAND THAT I HAVE ANSWERED AS ACCURATELY AS POSSIBLE TO THE ABOVE QUESTIONS, AND THAT I WILL UPDATE MY PRACTITIONER OF ANY CHANGES TO MY BODY'S HEALTH AT FUTURE VISITS.

I ALSO GIVE CONSENT FOR THE HEALING / TREATMENT TO TAKE PLACE.

SIGNED _____

PRACTITIONER SIGNATURE _____