5 Lights Wellness (206) 601-6290
1417 NW 54th St. Seattle, 98107

Personal Information

Client Name: _____ Today's Date: _____

Age: _____ Birth Date: ____/____/____ Gender: M__ F__ T__
Have you had energy work before? Y__ N__

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Employer/Occupation: _____

How did you hear about us? _____

Emergency Contact: _____ Phone: _____

Main Concerns
Please identify your major concerns/ how long has it been going on?
1.

2.

3.

Personal Medical History *(Please include your childhood history)*
Illnesses:

Surgeries/dates:

Trauma: (i.e. motor vehicle accidents, fractures, abuse, etc.)

Do have a history of current or past infectious disease? Please describe

Medicines (please list all medications, herbs, vitamins and over the counter drugs)

Allergies/Sensitivities (Foods, drugs, environmental factors, etc.)

General (please check all that apply)

❑ Weakness	❑ Hearing Loss	❑ Easy to Bleed or Bruise
❑ Sudden Energy Drops	❑ Fevers	❑ Sweat Easily
❑ Poor Sleep	❑ Chills	❑ Night Sweats
❑ Fatigue	❑ Puffiness or Swelling	❑ Tremors
❑ Muscle Pain	❑ Weight Loss	❑ Poor Balance
❑ Neck Pain	❑ Weight Gain	
❑ Back Pain	❑ Changes in Appetite	❑ Other:
❑ Arm Pain	❑ Poor Appetite	
❑ Wrist Pain	❑ Cravings	
❑ Leg Pain	❑ Strong Thirst	
❑ Ankle Pain		

Musculo-Skeletal

❑ Arthritis ❑ Scoliosis	❑ Muscle Weakness ❑ Weak Joints	❑ Muscle Cramping ❑ Pain with Weather	❑ Muscle Spasms Pain changes: ❑ With activity ❑ After waking

Cardiovascular

❑ High Blood Pressure ❑ Low Blood Pressure ❑ Irregular Heartbeat ❑ Palpitations	❑ Chest Pain ❑ Blood Clots ❑ Lightheadedness ❑ Fainting	❑ Swelling of Hands ❑ Swelling of Feet ❑ Cold Hands or Feet

Respiratory

❑ Cough ❑ Bronchitis ❑ Difficulty Breathing	❑ Phlegm ❑ Coughing Up Blood ❑ Pneumonia	❑ Asthma ❑ Painful Breathing ❑ Easily Winded

Gastro-Intestinal

❑ Nausea ❑ Constipation ❑ Diarrhea	❑ Bad Breath ❑ Ulcers ❑ Abdominal Pain ❑ Chronic Laxative Use	❑ Vomiting ❑ Intestinal Gas ❑ Belching ❑ Indigestion	❑ Rectal Pain ❑ Blood in Stools ❑ Hemorrhoids

Skin

❑ Rashes ❑ Itching	❑ Skin Ulcers ☑ Eczema	❑ Hives ❑ Recent Moles

Neuro-Psychological

❑ Seizures ❑ Areas of Numbness ❑ Concussion	❑ Irritability ❑ Stress ❑ Poor Memory	❑ Depression ❑ Anxiety ❑ Mood Swings	❑ Tremors ❑ Lack of Coordination ❑ Loss of Balance

Head, Eyes, Ears, Nose, and Throat

❑ Dizziness ❑ Facial Pain ❑ TMJ Pain ❑ Migraines ❑ Headaches ❑ Concussion	❑ Eye Strain/Pain ❑ Night Blindness ❑ Spots in Front of Eyes ❑ Cataracts ❑ Blurry Vision	❑ Poor Hearing ❑ Ear Ringing ❑ Ear Aches ❑ Nose Bleeds ❑ Sinus Problems	❑ Toothache ❑ Taste/Smell Problems ❑ Recurrent Sore Throat ❑ Lip or Tongue Sores ❑ Other: _____

Urology

❑ Painful Urination ❑ Urgency to Urinate ❑ Unable to Hold Urine	❑ Decrease in Urine Flow ❑ Frequent Urination ❑ Blood in Urine	❑ Cloudy Urine ❑ Kidney Stones ❑ Frequent Night Urination ❑ Sexually Transmitted Disease____

Gynecology

_____# of Pregnancies _____# of Births ❑ Menopausal	❑ Irregular Periods ❑ Painful Periods ❑ PMS	❑ Yeast ❑ Fertility Challenges	❑ Spotting ❑ Breast Lumps

Financial Agreement

Payment Arrangements

In order to maximize time on client care, we are not currently accepting or directly billing insurance companies. Payment is due in full at the time of service. Know you healthcare coverage; some insurance companies may reimburse you for services. It is your responsibility to understand your individual policy.

Please keep in mind giving you quality care that can support your wellbeing and desired changes is of prime importance to me. As so, I am open to discussing any special arrangements should it be necessary.

Cancellation Policy

We do require 24 hour notice for cancellations. By signing this form you are agreeing to pay a $65 fee for cancellations less than 24 hours.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office and will be glad to answer any further questions that you might have.

I have read and agree to the above.

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Client Signature **Date**