Innerlife
HEALTH SERVICES

Confidential Client Intake and Health History Form

The information you provide will assist the practitioner in treating you safely and will be kept confidential unless allowed or required by law.

Contact and Personal Information

Date: ____________________ Name: ______________________________________

Address: ____

City: ________________ Province: __________________ Postal Code: __________________

Phone Home: ________________Cell: ________________Work: ______________________

Email: __________________________________ Date of birth (dd/mm/yy): ______________

Emergency contact (name & number): ____

Occupation: ____

Were you referred by someone? ____

May we contact you via: ☐ phone ☐ email ☐ text

Health History (* Please answer the following questions to the best of your ability)

What are your primary reasons for today's visit?

____

____

Do you have other desired goals for these sessions? What are they?

____

____

Relevant medical history (injuries, surgeries, accidents, events within the last 5 years or previously):

____

____

List the medications (including over the counter) you are presently taking and what conditions they are for:

____

____

List any supplements you are taking: ____

Primary Healthcare physician: ____

Please list any other healthcare professionals you are seeing:

____

Please list any medical tests you have had within the past year:

____

Presence of medical or engineered components (ex. Prosthetics, pacemakers, implants, pins, etc):

____

Medical contraindication markers including (please mark):

- ☐ Cardiovascular conditions
- ☐ Respiratory conditions
- ☐ Family history of cardiovascular, respiratory and other conditions
- ☐ Infections
- ☐ Head and neck conditions
- ☐ History of headaches or migraines
- ☐ Vision or hearing loss/loss of sensation
- ☐ Allergies and/or hypersensitivities
- ☐ Systemic conditions (ex: diabetes, cancer, or multiple sclerosis)
- ☐ Arthritis and family history of arthritis
- ☐ Pregnancy
- ☐ Gynecological conditions
- ☐ Any other medical or health conditions

Please note any concerns/problems you have with the following:

DIGESTION:____
RESPIRATORY:____
CARDIOVASCULAR:____
URINARY:____
NERVOUS SYSTEM: ____
MUSCLES/JOINTS:____
OTHER:____
Allergies? List: ____

My family stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe

My relationship stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe

My work stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe

My financial stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe

My health stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe

My emotional stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe Other stress is_________________:

What do you do to relax?:____

Do you exercise? ☐ Yes ☐ No If so, what kind? _______________________and how often? _____________

Cigarettes/ week ____Alcohol/week ____Caffeine/ week ____Drugs/week
Any nutritional lifestyle/routine/diet?____

How many hours a night do you sleep? ______ Is your sleep restful? ☐ Yes ☐ No
If not, please explain: ____

Cancellation Policy:

Since time has been especially reserved for me, I understand that a 24-hour cancellation is required to avoid the full charge for my scheduled session. _______ (initials)

Informed Consent

I have informed the Practitioner of all my known physical/medical conditions and medications. I will keep the Practitioner updated on any changes to my health history. The Practitioner explained to me and I understand:

- why a health history is needed before a session begins
- that I may ask questions about the information being requested and my therapeutic process at any time
- that all client information is confidential and written authorization will be obtained prior to release of information to other caregivers or legal processes
- that the session provided by this Practitioner is intended to enhance relaxation, increase communication within the areas of the body, and to educate me to possible energetic or emotional blocks that may create pain and disease. Energy work is non-invasive, safe, and objective. It utilizes the body's own innate intelligence to re-establish communication within itself.
- the process of listening, observing, responding and shifting patterns of energy and communication within the body that the session will involve
- that at any time, I may withdraw my consent and the session will be stopped
- the duration and cost of the session
- that energy work is not a substitute for medical treatment or medications
- that it is recommended that I work with my Primary Caregiver for any condition I may have
- that an Intuitive Health Practitioner does not diagnose illness or disease and does not prescribe medications

I, ____, have read, understood and completed, to the best of my knowledge, the Health History form and the Informed Consent form. I release the Practitioner from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this client history form.

Client/Guardian Signature: ____Date: ______________________

Practitioner Signature: ___________________________________Date: ________________________________