

Thrive CommUnity Acupuncture & Massage

110 W. Harvard St., Fort Collins, CO 80525

Energy Healing Intake Form

| | | |
|-----------------------------------|---------------------|-----------|
| Name _____ | Date of Birth _____ | |
| Address _____ | City _____ | Zip _____ |
| Phone _____ | Email _____ | |
| Occupation: _____ | Hobbies: _____ | |
| Emergency Contact and Phone _____ | | |
| Today's Date: _____ | | |

Describe briefly your concerns, i.e. what brought you here today? _____

What will you be able to do better when your condition is improved? _____

How will you **feel** when your condition is improved? _____

Medications you presently take and for what conditions? _____

Surgeries within the past 5 years? _____

Were you ever hospitalized as a child? _____

Chronic conditions due to accidents or other causes? _____

Unless already stated, do you have any of the following? (*Star* issues that are most consistent, using the back if needed)

- | | | |
|--|--|--|
| <input type="checkbox"/> headache _____ | <input type="checkbox"/> eating issues _____ | <input type="checkbox"/> excessive sweating |
| <input type="checkbox"/> smoking habit | <input type="checkbox"/> sleep issues _____ | <input type="checkbox"/> difficulty making decisions |
| <input type="checkbox"/> allergies _____ | <input type="checkbox"/> poor digestion (belching, bloating, pain) | <input type="checkbox"/> tooth or gum problems |
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> sadness, <input type="checkbox"/> anger |
| | | <input type="checkbox"/> palpitations |

| | | |
|--|---|--|
| <input type="checkbox"/> trouble hearing | <input type="checkbox"/> menstrual issues | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> fears | <input type="checkbox"/> tinnitus, low or high? | <input type="checkbox"/> back pain |
| <input type="checkbox"/> restlessness | <input type="checkbox"/> lack of sexual desire | <input type="checkbox"/> joint stiffness |
| <input type="checkbox"/> skeletal system | <input type="checkbox"/> tend to be cold <input type="checkbox"/> tend to be warm | <input type="checkbox"/> excessive fatigue or listless |
| <input type="checkbox"/> cysts | <input type="checkbox"/> short of breath | <input type="checkbox"/> infertility |
| <input type="checkbox"/> cancer | <input type="checkbox"/> anxiety | <input type="checkbox"/> OTHER |

Informed Consent

I declare that the information I have provided is correct to the best of my knowledge.

I understand that information submitted to Thrive is held in strict confidence and will not be released without my written consent.

I understand that the representatives of Thrive do not claim or imply that services, advice, suggestions either in person, through email or telephone will cure or prevent any disease or condition.

I acknowledge that the representatives of Thrive recommends that I remain on any and all prescriptions that I may be taking at present and continue with current medical care.

I further declare that my healthcare is my responsibility and that Thrive is not accountable for any consequences of my decisions regarding my healthcare.

I understand, acknowledge, and voluntarily accept the risk associated with energy healing services, use of your facilities, and I hereby release you (including our affiliates, agents, and employees) from liability for any injury or claim (including, without limitation, personal, bodily, or mental injury, property damage or economic loss), which may result from your energy healing session, my failure to disclose any pre-existing condition, limitation or sensitivity, or my failure to inform my therapist of discomfort during my session.

Our therapists agree to adhere to a strict code of conduct designed to provide a safe, professional, and therapeutic environment for our patients and staff. In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration in the Department of Regulatory Agencies. If you have concerns about your experience, please bring it to the attention of management immediately. If you feel uncomfortable for any reason, ask your therapist to end the session. **Payment and**

Appointment Policies

I understand that I am responsible to pay for my scheduled appointment in full with cash, check or approved credit card on the date such service is rendered. Returned checks will be charged a \$20.00 service fee. **If I miss an appointment without giving at least 24 hour notification, I understand I will be billed the full session rate** (whether that appointment is prepaid or paid hourly), unless: 1. The appointment can be filled by another client, in this case your payment will be pro-rated to your next appointment or, 2. There is an approved emergency as determined on a case- by-case basis.

I have read, understood, and agree to the terms as stated by Thrive.

Signature _____ Date _____

If client is under 18 years old, parent or legal guardian must sign.

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