



15222 Madison Ave. • Lakewood OH 44107 • 216.671.7755

DATE OF FIRST VISIT:

Client Intake Form

INSTRUCTIONS: To fill this form out on your computer, click the tab key to move between fields and click directly on the squares. You can either print it out and bring it with you or email it at least 24 hours before your appointment.

NAME		STREET ADDRESS		CITY		STATE	ZIP
DATE OF BIRTH	PHONE	EMAIL ADDRESS			PROFESSION(S)		
# WORK HOURS/WEEK		#OF KIDS	#KIDS AT HOME	RELATIONSHIP STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> COHABITATING			
EMERGENCY CONTACT NAME		CONTACT PHONE		PRIMARY PHYSICIAN NAME		HOLISTIC PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Would you like to receive educational newsletters via email approximately every other month? <input type="checkbox"/> YES <input type="checkbox"/> NO							
Is this your first energetic bodywork session? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, check all modalities you have experienced: <input type="checkbox"/> CranioSacral Therapy <input type="checkbox"/> Reiki <input type="checkbox"/> Acupuncture <input type="checkbox"/> Accupressure <input type="checkbox"/> Polarity Therapy <input type="checkbox"/> Reflexology <input type="checkbox"/> Spiritual Healing Other:							
How did you hear about the Healing Room? <input type="checkbox"/> Advertisement <input type="checkbox"/> Website Referred by: Other:							
Any surgeries this past year? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, type of surgery:							
Have you had an accident in the past year? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, describe:							
Any additional surgeries or accidents? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, please describe:							
Are you sensitive to any scents, sounds, textures or light? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, describe:							
What are your methods of relaxation?							
What are your hobbies?							
Are you, or could you currently be pregnant? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, due date if known:							
List supplements you are currently using:							

Check any that you are using currently				
<input type="checkbox"/> Alcohol (social)	<input type="checkbox"/> Anti-Depressant	<input type="checkbox"/> Cortisone	<input type="checkbox"/> Pain Medication	
<input type="checkbox"/> Alcohol (heavy)	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Cholesterol Medication	<input type="checkbox"/> Refined Sugar	
<input type="checkbox"/> Antacid	<input type="checkbox"/> Blood Thinner	<input type="checkbox"/> Hormones	<input type="checkbox"/> Sleeping Pills	
<input type="checkbox"/> Allergy Medicine	<input type="checkbox"/> Coffee	<input type="checkbox"/> Laxatives or Stool Softener	<input type="checkbox"/> Thyroid Medication	
<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Cola, Soda, Pop	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Tobacco	
Check any that cause you concern (some items appear in more than one section):				
ROOT	<input type="checkbox"/> Money Issues	<input type="checkbox"/> Feet	<input type="checkbox"/> Blood	<input type="checkbox"/> Safety
	<input type="checkbox"/> Family Support Issues	<input type="checkbox"/> Bones	<input type="checkbox"/> Fear	<input type="checkbox"/> Self-Confidence
	<input type="checkbox"/> Low Back, Tailbone Pain	<input type="checkbox"/> Teeth (not gums)	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Calcium deficiency
	<input type="checkbox"/> Legs or Ankles	<input type="checkbox"/> Colon	<input type="checkbox"/> Frustration	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Knees	<input type="checkbox"/> Prostrate	<input type="checkbox"/> Insecurity	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Bladder	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Clumsiness	<input type="checkbox"/> Obesity
SACRAL	<input type="checkbox"/> Reproductive Organs	<input type="checkbox"/> Spleen	<input type="checkbox"/> Obesity	<input type="checkbox"/> STD's
	<input type="checkbox"/> Impotence	<input type="checkbox"/> Kidneys	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Constipation/Diarrhea
	<input type="checkbox"/> Kidneys	<input type="checkbox"/> Stiff Low Back	<input type="checkbox"/> Depression	<input type="checkbox"/> Addictions
	<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Skin	<input type="checkbox"/> Sciatica	
SOLAR PLEXUS	<input type="checkbox"/> Digestion	<input type="checkbox"/> Metabolism	<input type="checkbox"/> Procrastination	<input type="checkbox"/> Addictions
	<input type="checkbox"/> Liver or Gallbladder	<input type="checkbox"/> Small Intestines	<input type="checkbox"/> Reaching Goals	<input type="checkbox"/> Parasites
	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Confidence	<input type="checkbox"/> What Others Think	<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Self Esteem	<input type="checkbox"/> Self-Worth	<input type="checkbox"/> Diabetes/Blood Sugar	<input type="checkbox"/> Infections
	<input type="checkbox"/> Anger	<input type="checkbox"/> Confusion	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nervousness
HEART	<input type="checkbox"/> Lungs	<input type="checkbox"/> Muscles	<input type="checkbox"/> Indecisiveness	<input type="checkbox"/> Blood Pressure
	<input type="checkbox"/> Heart	<input type="checkbox"/> Sorry For Oneself	<input type="checkbox"/> Fear Of Letting Go	<input type="checkbox"/> Passiveness
	<input type="checkbox"/> Arms/Hands	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Fear Of Getting Hurt	<input type="checkbox"/> Muscle Tension
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Overly Empathic	<input type="checkbox"/> Feeling Ignored	<input type="checkbox"/> Breathing
THROAT	<input type="checkbox"/> Throat	<input type="checkbox"/> Shoulders	<input type="checkbox"/> Toothaches	<input type="checkbox"/> Hormonal Problems
	<input type="checkbox"/> Mouth Or Jaw	<input type="checkbox"/> Lymph	<input type="checkbox"/> OCD	<input type="checkbox"/> Hiccups
	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Suppressed Feelings	<input type="checkbox"/> Speech Disorders	<input type="checkbox"/> PMS
	<input type="checkbox"/> Tongue	<input type="checkbox"/> Frequent Colds Or Flu	<input type="checkbox"/> TMJ	<input type="checkbox"/> Mood Swings
	<input type="checkbox"/> Gums	<input type="checkbox"/> Cough	<input type="checkbox"/> Hyperactivity	
	<input type="checkbox"/> Neck	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Melancholy	
THIRD EYE	<input type="checkbox"/> Eyes/Eyestrain/Blindness	<input type="checkbox"/> Forebrain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nightmares
	<input type="checkbox"/> Nose	<input type="checkbox"/> Selfishness	<input type="checkbox"/> Eyestrain	<input type="checkbox"/> Sleep Disorders
	<input type="checkbox"/> Ears	<input type="checkbox"/> Assertiveness	<input type="checkbox"/> Memory	<input type="checkbox"/> Manic Depression
	<input type="checkbox"/> Sinuses	<input type="checkbox"/> Fear Of Success/Failure	<input type="checkbox"/> Anger	<input type="checkbox"/> Schizophrenia
	<input type="checkbox"/> Cerebellum	<input type="checkbox"/> Ego	<input type="checkbox"/> Migraines	<input type="checkbox"/> Paranoia
	<input type="checkbox"/> Pineal	<input type="checkbox"/> Equilibrium	<input type="checkbox"/> Nightmares	
CROWN	<input type="checkbox"/> Brain	<input type="checkbox"/> Depression	<input type="checkbox"/> Neuralgia	<input type="checkbox"/> Connection to the Divine
	<input type="checkbox"/> Pituitary	<input type="checkbox"/> Alienation	<input type="checkbox"/> Confusion	
	<input type="checkbox"/> Hair	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Senility	
Reason(s) for this visit :				
Anything else you would like me to know :				



Fran Kerg, Energy Medicine Practitioner
Reiki Master Teacher, Registered Board Certified Polarity Practitioner
Member of the American Polarity Therapy Association and
The American Holistic Medical Association

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Disclaimer and Client's Statement of Understanding

Disclaimer: The practices which Fran Kerg has trained in have not yet been made the subject of extensive US scientific or medical study, and the results attributed to them are therefore considered anecdotal and subjective in the United States. These practices are as follows:

- Usui Reiki
- CranioSacral Therapy
- Polarity Therapy
- Lightarian Reiki
- Reconnective Healing
- Matrix Energetics
- Whole Life Healing
- Emotional Freedom Technique
- Energy Interference Patterning of DNA
- Shamballah Multidimensional Healing
- The Emotion Code
- The Art of Neutrality

Client's Statement of Understanding: I, the undersigned, do hereby fully and clearly understand that Energy Medicine modalities are complementary healing, and may be an enhancement to, not a substitute for, conventional medical or psychological diagnosis and treatment.

I understand that energy medicine practitioners do not diagnose physical or mental conditions, prescribe or perform medical treatment, or prescribe substances.

I understand and agree that, as my energy medicine practitioner does not interfere with my treatment by any licensed medical professional, a decision to forego use of or change the dosage of any prescribed medication is mine alone and not done at the suggestion or inference of the practitioner.

I agree that no claims of miracles and cures have been made, expressed or implied, and it has been recommended that I see a licensed healthcare professional for any physical or psychological ailments.

I understand that personal information regarding my energetic bodywork sessions will not be shared by my energy medicine practitioner with any third party (including any of my other healthcare providers) without my express permission.

PRINT NAME	SIGNATURE	DATE SIGNED
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