



# Healing Arts

CHIROPRACTIC

HEALTH & WELLNESS CENTER

## **Client Information (All information is completely confidential) Please print clearly.**

Purpose of this session: \_\_\_\_\_  
Fears/Phobias? Please List: \_\_\_\_\_

Ever been treated for: Diabetes – Epilepsy – Heart Disorder – Digestive Problems – Emotional Issues  
Explain: \_\_\_\_\_

Are you presently under a doctor’s care? Yes No  
Explain: \_\_\_\_\_

I have your permission to contact your physician if it is appropriate. \_\_\_\_\_ (Initials)

Quality of life for today:                      Excellent    Fine    Just OK    Not Good

Quality of life this past week:                      Excellent    Fine    Just OK    Not Good

Do you generally sleep through the night?    Excellent    Fine    Just OK    Not Good

Do you generally waken feeling refreshed?    Excellent    Fine    Just OK    Not Good

Emotional/Physical Pain level today (1-10; 10 unbearable):    1 2 3 4 5 6 7 8 9 10

Emotional/Physical Pain during this past week:                      1 2 3 4 5 6 7 8 9 10

Referred by: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that Energy Work/Shamanic Healing is not a substitute for medical or psychological diagnosis and treatment. I also understand that Energy Workers/Shamanic Practitioners do not diagnose conditions, do not prescribe or perform medical or psychological treatment, and do not interfere with the treatment of licensed medical or psychological professionals. I am willing to participate in Energy Work/Shamanic Healing for the purposes of self-improvement. It is recommended that I see a licensed physician or health care professional for any physical or psychological ailments I might have.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

