Client Information

Date:_____/_____/_____ Name:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____ Email:_____ Birthdate:____/____/_____
May I add you to my monthly email newsletter? Y N

Whom may I thank for referring you?_____

Have you experienced Healing Touch or other energy therapy before?_____

Living situation: married / partner / single # of children:_____ Occupation:_____

Health care professionals you are currently working with (circle all that apply): MD DO Chiro Acupuncture

Massage Other:_____

Are you currently taking any medications? Y N If yes, what?_____

Have you had any illnesses, injuries, trauma, or surgeries that may be affecting your health now? Y N Explain:

_____

_____

Are you currently experiencing any symptoms (pain, tension, anxiety, etc)? Y N Explain:_____

_____

How does this affect your daily activities (sleep, exercise, decision-making, relationships)?_____

_____

For those symptoms/concerns that apply to you, please rate your distress level for each using the scale below:

0 1 2 3 4 5 6 7 8 9 10
None Very little Somewhat Moderate Considerable Maximum

___Depression ___Mood swings ___Anger ___Alcohol/drug use
___Sleep problems ___Anxiety ___Panic attacks ___Memory problems
___Eating problems ___Hormonal imbalances ___Allergies_____
___Stress (work) ___Stress (home) ___Other_____

How stress manifests:_____

Religious/spiritual practice:_____

What is your goal for today's session?_____

Long term health goal/s:_____

In case of emergency, I authorize Bonnie Thompson to contact the following person/s:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Anything else I should know about you? Questions?

Thank You

Bonnie Thompson, HTCP, EFT-ADV
Healing Tree Wellness LLC
215 W. Magnolia, Suite 202
Fort Collins, CO 80521
970.988.0566

I understand that:

- ✓ An assessment will be conducted to determine the general health of my energy system and this information will be shared with me.
- ✓ Any suggestion made by the practitioner will be to assist my body's natural ability to achieve a balanced state to the extent that my body/mind will allow.
- ✓ The goal of my treatment will be identified as part of the treatment process and I will have input into my goal setting.
- ✓ These sessions are not meant to replace treatment by established medical practices but to complement them.
- ✓ No guarantees as to the results of treatment are expressed or implied by the practitioner.
- ✓ All issues related to my session will be kept in confidence.

I agree to:

- ✓ Raise any questions about anything I do not understand.
- ✓ Consider any suggestions that the practitioner may raise concerning referrals to other health care practitioners.
- ✓ Take full responsibility for my own health care.
- ✓ Give consent to BONNIE THOMPSON to conduct a session to balance my energy system, which may include light touch and/or tapping at various points on my body.

CANCELLATION POLICY: If you must cancel a session, please give at least 24 hours notice. Your consideration is much appreciated. Missed appointments will be charged at the regular rate with allowances for emergency situations.

_____ _____

Name (please print) Date

_____

Signature

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