Lana Nimegeers, CAIEHP
Certified Advanced Integrative Energy Healing™

CLIENT INTAKE FORM

First Name: _____ Last Name: _____.
Home Phone: _____ Mobile Phone: _____

Email Address: _____
Address: _____

City: _____ Prov/State: _____ Postal/Zip Code: _____
Country: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

DOB: _____ (MM/DD/YYYY) Time of Birth: _____ Place of Birth: _____

Relationship Status: Married ___ Common Law ___ Divorced ___ Single ___ Separated ___

Number of Children _____ Ages _____ Pets _____

Living Situation: alone? With family? With Parents? With Roommate(s)? With Children?

_____

_____

Occupation: _____

How did you hear of me? _____

Health Care Professionals that you see regularly:

_____

_____

Current Medications:

_____

_____

Current Supplements:

_____

_____

Eating Habits/Diet: _____

_____

Exercise Routine/Sports/Activities: (if any) _____

_____

Creative Outlets: (Arts, Writing, Drama, Dance, Photography…)_____

_____

SpiritualBackground/Practices (if any): _____

_____

What **physical symptoms** are you experiencing and/or **ailments** have you been diagnosed with?

_____

_____

_____

What **mental and/or emotional symptoms** are you experiencing AND what **conditions** have you been diagnosed with?

_____

_____

_____

Injuries: List any past injuries and when they occurred AND List any current injuries:

_____

_____

_____

Surgeries: List any surgical operations you have had (and when) AND any upcoming surgeries:

_____

_____

_____

Trauma: List any traumatic or life-threatening events that occurred in your life, and when they occurred:

_____

_____

_____

_____

_____

_____

_____

_____

Reason for Visit?

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. Please feel free to ask any questions you have.

PROTECTION OF PRIVACY: The personal information requested on this form is collected and protected under the authority of Part 2 of the Alberta Freedom of Information and Protection of Privacy Act. It will be used for the purpose of client intake and assessment only.

CONSENT TO RECEIVE ADVANCED INTEGRATIVE ENERGY HEALING™ SERVICES

I hereby consent for my Health Practitioner, Lana Nimegeers, to treat me with Advanced Integrative Energy Healing™ (AIEH) for the purposes that I have sought treatment for.

I acknowledge that my AIEH Practitioner is not a physician and does not diagnose illness nor disease nor any other physical or mental disorder. I clearly understand that AIEH is not a substitute for medical examination. It is recommended that I attend a qualified medical professional for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatments I will receive.

I acknowledge that with any treatment there can be risks. I am aware that the risks of AIEH are minimal and include, but are not limited to the potential for emotional release, dizziness and temporary aggravation of symptoms.

I acknowledge and understand that my AIEH Practitioner must be fully aware of my existing medical conditions and the medications that I am taking. I will disclose to my AIEH Practitioner all of the medical conditions affecting me and the medications that I am taking. It is my responsibility to keep my Practitioner updated on my medical history and any change in my medications.

I release the practitioner and all affiliates from any liability, past, present or future relating to treatment received at this clinic and from problems arising from the treatment or as a result of information not given or incorrectly given in this health history.

The information I have provided is true and complete to the best of my knowledge.

By signing this form, I confirm my consent to treatment and intend this consent to cover the treatments discussed with me and such additional treatments as proposed by my AIEH Practitioner from time to time, to deal with my physical conditions and for that which I have sought treatment.

I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand that payment is required at the time of service.

I understand that if I need to cancel any appointment 24 hours notice is required, otherwise I will be responsible to pay 50% of the scheduled appointment fee.

_____	_____	_____
Date	Client Name (Print)	Client/Guardian (Signature)