Energy Alignment Session Intake Form

Please print clearly and complete all the responses to the best of your knowledge. All Information will be strictly confidential.

Name: ____

Email: ___________________________________

Address:____

Home/Business Phone: _______________________________

Cell Phone: ____________________________________

D.O.B (D/M/Y): _____________________________ Age: ______ Sex: M / F /

Emergency Contact: ____

Phone: ______________________________

How did you hear about us?

____

Are you presently under the care of a doctor/health practitioner? Y / N /

Primary health concern:____

____

Are you on any form of medication? Y / N /

List:____

Do you have any restrictions in movement Y / N /

Are there any stretches or yoga postures which may be harmful?

____

Are you involved in regular physical activity? Y / N What type? /

____

Please indicate which of the following apply to you:

____ Aids ____ Fractures ____ Osteoporosis ____ PTSD

____ Allergies / sinus ____ Headaches ____ Phlebitis (DVT)

____ Aortic aneurysm ____ Heart disease ____ Pregnancy - Due Date:_________

____ Arteriosclerosis ____ Hemophilia ____ Recent surgery

____ Arthritis ____ Hernia ____ Rheumatoid arthritis

____ Cancer ____ Hepatitis A / B / C ____ Skin disease

____ Cervical spine problems ____ High blood pressure ____ Stroke

____ Clicking/popping ears/jaw ____ Joint problems ____ Tooth/jaw pain

____ Constipation ____ Kidney/bladder ____ Varicose veins

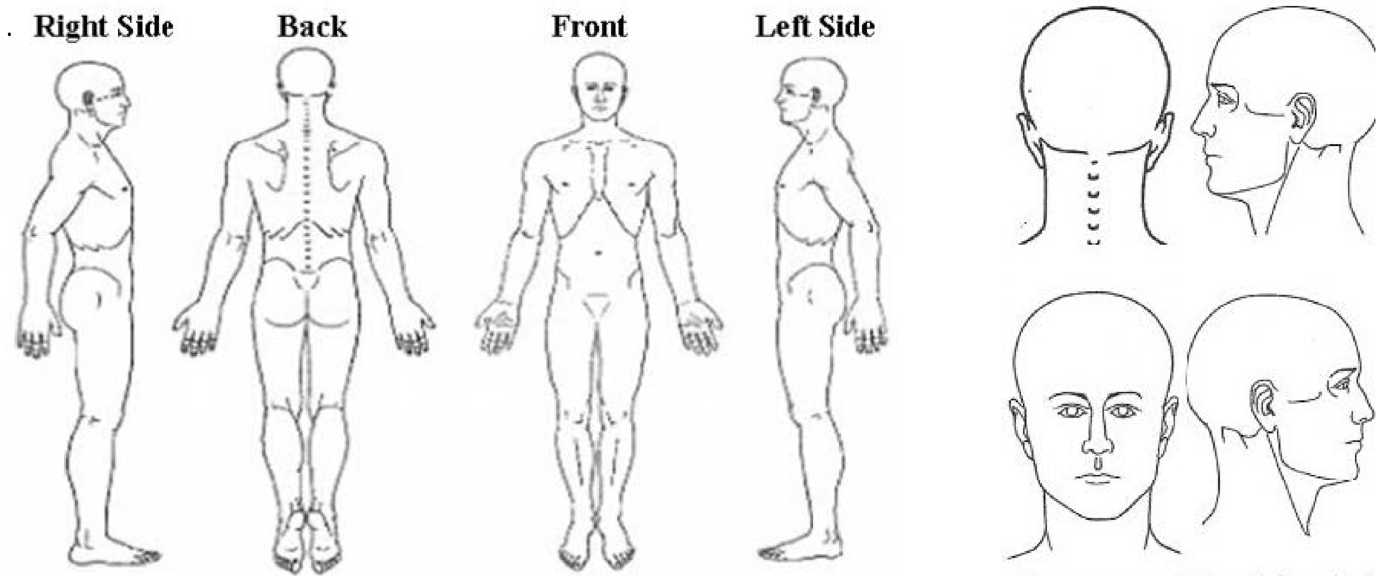
____ Diarrhea ____ Liver/gallbladder ____ Menstrual problems

____ Difficult digestion ____ Other: List below

____

____

Musculoskeletal - Please indicate areas of pain by marking in affected areas



Consent for Treatment

I, undersigned, do hereby give my voluntary consent for the administration of treatment deemed appropriate by Practitioner Stephanie Lafazanos, Kinesiologist, Holistic Practitioner and Certified Medical Intuitive.

I understand that Energy Alignment Sessions are not a medical diagnosis, but that they include an intuitive interpretation of my holistic health and may include information that may be beneficial for awareness of the bio-psycho-social connections and causation of my issues, current or previous habits and recommendations for healing or outside therapies when it is beyond the Practitioners scope of practice. Treatment may include individualized exercise prescription, various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches. Modalities such as kinesiology, somatic therapies, energy work, massage, qigong, Tao yoga, tantra and counselling may be used.

I understand that the primary goals of the Practitioner's treatments are to help guide my healing direction, make recommendations, increase awareness about my health in a holistic way, reduce my pain, stress, tension and improve my breathing, mobility, emotional balance, mental health and quality of life.

I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the Practitioner to anticipate all the possible risks and complications. I wish to rely on the Practitioner to exercise proper judgment during the course of treatment to make decisions based upon my best interest.

Potential small but possible risk factors: Manual therapy: Joint and/or muscle soreness
Exercise therapy: Joint and/or muscle soreness

Client’s signature: ____

Date: ______________________________