

INTAKE FORMS FOR HEALING SESSION

Engaging in energetic healing work can be a deeply transformative experience. Please take your time filling out these intake forms. The questions are designed not only to give me a better sense of your experiences, but also to give you an opportunity to reflect on where you've been and what kind of intention you'd like to set going forward. If any question feels difficult or uncomfortable for you to answer, please indicate that. Notice what feelings or thoughts the question brings up. Notice what happens in your body in response to it. This is information that will help me better attune to you, so please share as much as you feel comfortable sharing.

To help guide your session (and to help you gain a deeper understanding of yourself), below are some suggestions for the days leading up to your session:

- * Spend some time journaling about your life as it is right now, both the areas where you feel satisfied and the areas where you long for a different experience. Try to look at your life as if you were a "curious observer," looking from some distance, without any judgement or expectations.

- * Spend a few minutes in quiet contemplation of your breath. Does your breath flow smoothly, or does it feel constricted? How freely does your chest expand when you breathe? How about your belly? Do you feel yourself holding anywhere?

- * Spend a few minutes connecting with your body by bringing your attention to each area, starting with either your head or your feet and working your way up or down. Notice how each part of your body feels. Where does your body feel open? Where does it feel tight or constricted? Move each of your joints. Do some move more easily than others?

Take note of whatever you observe in each of these exercises and write down whatever you'd like to share with me when you come.

Finally, because of the sensitivity of this work, I ask that you please refrain from using alcohol or drugs (except for over the counter or prescription medicine) for at least 24 hours before your session. This is both for your safety and the efficacy of the work. As a personal request, I also ask that you refrain from wearing perfume or cologne the day of your session.

CONTACT INFORMATION

Name:

Address:

Phone Number Home:	Work:	Cell:
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Email:	Date of Birth:
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Occupation:	Married/Single/Divorced? Children (please list age)?
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Emergency Contact
Name/Phone number:

Were you referred by someone?

GETTING TO KNOW YOU

What do you do for fun? What are your creative outlets?

What self-care practices do you have? How often do you do them?

Have you had any counseling or therapy? Have you ever been diagnosed with (or hospitalized for) mental illness?

Do you have a religious or spiritual practice (yoga, meditation, prayer, etc.)? If so, please describe.

Do you drink alcohol or use recreational drugs (including tobacco)? If so, how often/how much?

Do you have any physical limitations that would prevent you from fully participating in somatic exercises?

Is there a specific challenge you'd like to work on or an intention you'd like to set?

Is there anything else you would like me to know about you or that you'd like to share?

MEDICAL INFORMATION

Are you currently seeing a medical practitioner? If yes, please explain why.

List current medications you are taking, including aspirin, ibuprofen, herbs, etc.:

Describe any chronic health problems:

Please list all accidents, injuries or surgeries (not listed elsewhere), along with the approximate dates they occurred:

Please check any symptoms you are experiencing or have experienced in the recent past:

- | | |
|---|--|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Chronic sore throat, raspy throat |
| <input type="checkbox"/> Sciatica depression | <input type="checkbox"/> Mouth ulcers or gum disease |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Jaw problems/TMJ |
| <input type="checkbox"/> Numbness or tingling in legs | <input type="checkbox"/> Laryngitis |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Rectal problems/hemorrhoids | |
| | <input type="checkbox"/> Brain tumor |
| <input type="checkbox"/> Ob/Gyn problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Impotency/sexual issues | <input type="checkbox"/> Neurological disturbances |
| <input type="checkbox"/> PMS, cramps, bloating, painful periods | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Deafness |
| | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Intestinal problems, indigestion/IBS | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Frequent heartburn | |
| <input type="checkbox"/> Kidney/bladder problems, UTI | <input type="checkbox"/> Insomnia/sleep issues |
| <input type="checkbox"/> Anorexia/Bulimia/Issues with food/appetite | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Liver dysfunction | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Adrenal dysfunction | <input type="checkbox"/> Cancer (please describe): _____ |
| <input type="checkbox"/> Skin conditions (rashes, warts, etc.) | <input type="checkbox"/> Genetic disorders |
| <input type="checkbox"/> Seasonal, food, pet or other allergies | <input type="checkbox"/> Multiple sclerosis |
| | <input type="checkbox"/> Drug/alcohol/tobacco addiction |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Respiratory problems, including asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Upper back, shoulder pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Breast problems/breast cancer | <input type="checkbox"/> Other (please describe): _____ |
| | <input type="checkbox"/> _____ |

CONSENT AND RELEASE

It is important that you read, understand and sign this consent and release form.

I, _____, the undersigned, understand that an energy balancing/healing session is not a substitute for medical or psychological diagnosis and treatment. Healing practitioners do not diagnose conditions, nor do they prescribe medications nor perform medical treatment. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological ailment I have.

I acknowledge that Kim Lohret is not responsible for any medical diagnosis, treatment or psychological changes which may result from my participation in energy balancing/healing work. I understand that this work may lead to great change and transformation in my life. I accept this possibility and still choose to participate in these sessions. If emotional issues come up that I need help with, I understand that you recommend that I see a qualified professional for assistance.

I certify that, to my knowledge, I do not have any medical or psychological condition or any physical issues which would prohibit me from participating in this work. If I am currently using any medication or am under medical or psychological care, I have disclosed such on the medical history form.

I hereby acknowledge that I have read this informed consent, and am satisfied that I fully understand it. I, for myself, my executors, administrators and assigns, hereby hold Kim Lohret harmless from any and all claims for damages due to malpractice, nondisclosure, lack of informed consent, or any other claim, no matter how caused. I freely assume any and all risks of participation, whether presently contemplated or hereinafter discovered.

In the spirit of being fully responsible for myself, I am open to receive and benefit in all ways and on all levels from this work.

By typing or signing my name on the signature line below, I hereby indicate my agreement to this Consent and Release.

Signature:	Date:
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SERVICE AGREEMENT

WORK AGREEMENT

It is agreed that the client shall make a good faith effort at personal growth and engage in the healing process as an important priority at this time in his or her life. Suspension, termination or referral shall be discussed between healer and client for a pattern of behavior that reveals disinterest or lack of commitment to healing or any unresolved conflict or impasse between healer and client.

POLICIES

Sessions start on time and will not go over if client is late. Please make every effort to be on time. Please refrain from any alcohol or drug use (except prescription or over the counter medications) 24 hours before session and 48 hours afterwards. This is for your safety and the efficacy of the healing work.

FEE AGREEMENT

The agreed upon fee per session is \$90 for a 60-minute session, \$105 for a 75-minute session, and \$120 for a 90-minute session. Clients are fully responsible for payment in full at completion of session. Returned checks shall incur a \$25 return fee. Clients shall be notified of any increase one month prior to such increase going into effect.

CANCELLATION POLICY

Clients are asked to be responsible regarding appointment times. **Any appointment cancelled without 24 hours prior notice will incur: (a) a \$35 fee for the first instance; (b) the full fee rate for any instance thereafter.** All fees will need to be paid before any further appointments can be scheduled. 48-hour notice is greatly appreciated, so that I might have the chance to offer the appointment time to another that may need it.

CONFIDENTIALITY POLICY

All communications, records and contact will be held in strict confidence. Information may be released only when (1) the client signs a written release authorizing this, (2) the client expresses serious intent to harm himself/herself or someone else, (3) there is evidence or reasonable suspicion of abuse of a minor or elderly person, or (4) subpoena or other court order is received directing the disclosure of this information.

Signature:	Date:
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