PLEASE READ CAREFULLY

I understand that the Eden Energy Medicine sessions I receive are provided for the basic purpose of balancing my body's energies. If I experience any discomfort during a session, I will immediately inform my practitioner.
I further understand that Eden Energy Medicine practitioners do not diagnose, treat, or prescribe for medical conditions. The Eden Energy Medicine work in no way precludes treatment from my physician, therapist, hospital, chiropractor and/or any other medical treatments or medications currently prescribed. Energy work sessions are designed to be complementary to traditional medicine.

Signature: _____ Date: _____

Please list the names and specialties of your primary physician and other health care professionals you are currently seeing, with the approximate last dates of your visits:

_____ _____

_____ _____

_____ _____

Main problem(s) you would like me to help you with:

_____

_____

_____

_____

To what extent does this problem interfere with your daily activities?

_____

_____

Have you been given a diagnosis for this problem? If so, what?

_____

_____

What kind of treatments have you tried, and what was their effectiveness?

_____

_____

_____

Past medical history (please include dates)**:**

Significant Illnesses (Diabetes, Cancer, High Blood Pressure, Heart Disease, Stroke, Seizures, Digestive, Hormonal, Asthma, Allergies, Mental Illness, others):

_____

_____

_____

Medicines (taken in the past two months):

_____

_____

_____

Surgeries (please include dates)**:**

_____

_____

_____

_____

Significant Trauma (auto accidents, falls, etc.):

_____

_____

_____

Traumatic Life Events:

_____

_____

_____

Allergies (drugs, chemicals, foods):

_____

_____

Occupational stress (chemical, physical, psychological, etc.):

_____

_____

Do you have a regular exercise program? Please describe:

_____

_____

Please describe your general diet:

_____

_____

Do you smoke? _____ How much alcohol do you drink per week? _____

Please check if you had (in the last three months):

GENERAL	X		X		X
Fatigue		Sleep problems		Change in Appetite	
Sudden energy drops		Night Sweats		Changes in hearing or vision	
Chronic pain		Chills		Bleed or Bruise easily	
Fevers		Weight Loss		Localized weakness	
Digestive issues		Weight Gain		Poor Balance	
Skin problems		Allergies			

GASTROINTESTINAL	X		X		X
Nausea		Vomiting		Chronic laxative use	
Constipation		Gas		Black stools	
Abdominal Pain or cramps		Diarrhea		Hemorrhoids	
Acid Indigestion		Belching		Other issues	

MUSCULARSKELETAL	X		X		X
Muscle Pain		Shoulder Pain		Ankle/Foot Pain	
Muscle Weakness		Hand/Wrist Pain		Knee Pain	
Back Pain		Hip Pain			
Neck Pain		Legs Pain			

CARDIOVASCULAR	X		X		X
High Blood Pressure		Dizziness		Cold hands and feet	
Low Blood Pressure		Chest pain		Swelling hands or feet	
Irregular Heart beat		Difficulties of breathing			
Blood clots		Fainting			

RESPIRATORY	X		X		X
Cough		Pneumonia		Difficulties in breathing	
Bronchitis		Asthma		Other	

NEUROPSYCHOLOGICAL	X		X		X
Seizures		Poor memory		Emotional reactivity	
Depression		Lack of coordination		Feeling overwhelmed	
Easily susceptible to stress		Dizziness			
Anxiety		Loss of balance			

HEAD, EYES, EARS, THROAT	X		X		X
Headaches (where)		Ringing in ears		Cataracts	
Migraines		Poor hearing		Floaters	
Sinus problems		Poor vision		Thyroid issues	

URINARY, GYNECOLOGIC	X		X		X
Menopause (Age)		Irregular periods		Impotency	
Number of birth ( )		Frequent urination		Kidney stones	
Miscarriages		Urgency to urinate			

Comments (please tell me about anything else you'd like discuss or address):

_____

_____

_____

_____

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_____