



BIOFIELD TUNING

Client Intake Form

First name:

Last name:

Date of Birth:

Home Phone:

Cell Phone:

Email:

Address:

City/Province:

State:

Post Code:

Please mark all that apply and provide any additional health information that you'd like us to know:

- | | |
|---|---|
| <input type="checkbox"/> Pregnancy or planning to become pregnant | <input type="checkbox"/> Recent broken bones |
| <input type="checkbox"/> Cancer or terminal illness | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Heart condition/pacemaker | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Concussion or head injury in the last 6 months | <input type="checkbox"/> Currently taking medications |
| | <input type="checkbox"/> Other |

If other, please describe:

List any goals that you may have for our session today and for your long term health:

I grant my practitioner permission to use light touch and the application of weighted forks on my body. I am aware that I may verbally revoke this permission before or during my session at any point.

Signature of Client:

(or Parent/Guardian if client is under 18)

_____ Date: _____

I have provided my information to the best of my knowledge, including pertinent health information.

Signature of Client:

(or Parent/Guardian if client is under 18)

_____ Date: _____