The Flying Cat
Gallery & Healing Arts Studio

Julia Martin, Certified Yoga Instructor & Energy Healing Practitioner

CLIENT INFORMATION

Name ____ Date ___/____/____

Address _______________________City_________State___Zip Code_______

Phone:: Home _____________ Work ___________ Birth Date ___/____/______

e-mail address ____

Occupation ____________________________ Employer _________________

Referred By ____________________________ Marital Status ______________

Current Problem or Complaint ____

_____________________________________ Date of Onset ____/___/______

DESIGNATE ANY OF THE FOLLOWING YOU (C) CURRENTLY EXPERIENCE OR HAVE

EXPERIENCED IN THE (P) PAST.

PLEASE PLACE A (C) FOR CURRENT OR A (P) FOR PAST IN THE SPACE PROVIDED.

____ jaw discomfort

____ headaches

____ sinus problems

____ concussions/head injuries

____ leg pain

____ muscle spasms/cramps/pains

____ high/low blood pressure

____ arthritis or rheumatism

____ broken/cracked bones

____ sprains/dislocations

____ irregular sleep patterns

____ anxiety or nervousness

____ alcohol/drug dependency

____ vision problems

____ heart disease

____ heart palpitations

____ respiratory problems

____ lung disease

____ cancer

____ fatigue

____ depression

____ numbness in arms/legs

____ ADD or ADHD

____ back pain

____ digestive problems

____ colitis/bowel disease/constipation

____ diabetes

____ bursitis/tendonitis

____ verbal abuse

____ sexual abuse ________________________

____ nasal drip

____ incontinence of urine or stool

____ cold limbs

____ gas

____ allergies

____ hearing loss

____ dry skin

____ night sweats

____ mouth ulcers

____ emotions (clarify below)

____ grief/sadness

____ bouts of anger

____ stress/over-thinking

____ inability to make decisions

____ other ________________

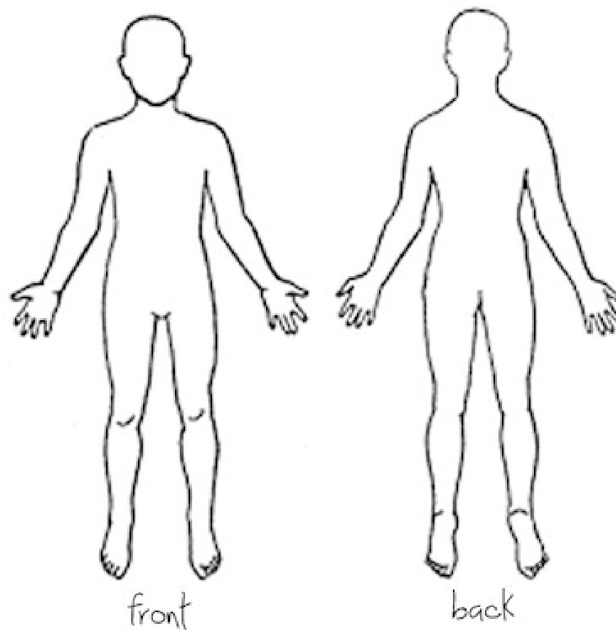
Do you smoke? ____ Yes ____ No If yes, how much? ____________

Do you have a challenge with weight control? _____ Yes ____ No

Regarding your diet, do you have intake of sugar _____ Yes ____ No

caffeine _____ Yes ____ No

Please indicate areas of pain n your body:



List any hospitalizations, surgeries, or traumatic accidents (give dates):

____

____

____

List any allergies:

____

List present medications (include all prescription and over-the- counter drugs, vitamins, supplements, birth control pills, etc.):

____

____

What is/are your reason(s) for scheduling this session?

____

____

Why are you thinking that now is the time for you to experience Energy Healing?

____

____

What is happening in your life now that is encouraging or causing you to have chosen to make your first appointment now?

____

____

Is there anything that stands in your way of allowing this healing process to work for you?

____

____

Please briefly describe what your life will look like/feel like when you accomplish your goal(s) for this/these sessions?

____

____

Are you willing to do the inner work necessary to achieve the outcomes you desire?

Please rate your willingness on a scale from 1 to 10 (1-low, 10-high).

____

Have you ever had previous experience with Energy Healing?

____

____

Are you currently seeing another medical professional, therapist, etc. in relation to your overall health? If so, please describe.

____

____

Is there anything else you would like Julia to know before your session(s)?

____

____

This form is designed to assist Julia in developing effective and interactive communication with you. The intent is to allow you an opportunity to become a partner in your healing process. The service provided here at the The Flying Cat is sacred and important. If you find you are unable to keep your scheduled appointment, we ask you to take responsibility for canceling appointments 24 hours in advance of your scheduled time. If you have not appropriately canceled, you will be billed and asked to pay half of the original session fee. Thank you.

____ Date ___/___/____

(Client Signature)

Thank you for being here today!