East House
natural health centre

Client Intake

NAME: _____ **DATE:** _____

ADDRESS: _____

City:_____ **Prov:** _____ **Postal code:** _____

DAY PHONE: _____ **MOBILE:** _____

Date of Birth _____ **E-mail:**_____

How did you hear about us? ☐ Website ☐ Referral Whom may we thank? _____

. . . . . .

Occupation _____ Are you currently pregnant: ☐ Y ☐ N

Family situation: ☐ Single ☐ Living alone/roommate ☐ Living with parents ☐ Living with partner
☐ Married ☐ Separated ☐ Other
☐ Children: how many _____ ages _____

What other treatments are you having? _____ have tried? _____

Do you suffer from any of the following: Please write C (current) or P (past)

___Acid Reflux	___Cholesterol	___High Blood Pressure	___Pain: back, neck, shoulders
___Acne	___Constipation	___HIV/Aids	___Pain: joints
___ADD/ADHD	___Crohn's Disease	___Indigestion	___Pain: muscles
___Addictions	___Depression	___Infertility	___PMS
___Allergies	___Diabetes/hypoglycemia	___Insomnia	___Poor Circulation
___Anxiety/Anxiety Disorder	___Diarrhea	___Irritable Bowel Syndrome	___Prostate
___Arm/hand numbness	___Diverticulitis	___Kidney Infection	___Repeated infections
___Arthritis	___Dizziness	___Kidney Stones	___Runny eyes or nose
___ASD/autism/Asperger's	___Dyslexia	___Lack of Concentration	___Seizures
___Asthma	___Eczema	___Learning disabilities	___Sinus stuffy/ problems
___Back problems	___Endometriosis	___Liver Problems	___Skin Problems/Rash/Hives
___Bipolar/mental illness	___Fainting	___Low Blood Pressure	___Sleep
___Bladder Infection	___Fatigue/Low Energy	___Low Immunity	___Sore throat
___Bronchitis/Respiratory	___Fibromyalgia	___Low sex drive	___Stroke
___Bursitis	___Food cravings	___Menopausal problems	___Tendonitis
___Cancer	___Gall Bladder Attacks	___Menstrual Problems	___Thyroid Problems
___Candida/Yeast Problems	___Genital issues	___Migraines	___Tinnitus/ear ringing
___Canker/Cold Sores	___Hay Fever	___Mood Swings	___Twitches/ tremors
___Celiac disease	___Headaches	___Multiple sclerosis	___Ulcers
___Carpal Tunnel Syndrome	___Hearing problems	___Neuropathy/feet numb	___Urination
___Chronic Fatigue Syndrome	___Heart Problems	___Osteoporosis	___Vision problems
___Chronic Pain	___Heavy Metals	___Other:	___Weight Problems
___Colitis	___Heartburn	___Other:	

Are you aware of any allergies? ☐Y ☐N Please list your suspicions on what triggers you:

_____

Are you currently being treated for any medical conditions? ☐Y ☐N If yes, for what and how long?

_____

Please list any medications, herbs, vitamins or supplements you are currently taking:

_____

_____

Please list any major accidents, broken bones, concussions, whiplash, sports injuries, etc.:

_____

_____

Please list any surgeries (with approx. age when done):

_____

_____

Have you had major dental work done (braces, teeth removed, root canals, crowns, bridges, implants, or a lot of amalgam (silver fillings.) :

_____

_____

Are you happy with your weight? ☐Y ☐N If not, what is your ideal weight? _____

Are you on a special diet? ☐Y ☐N If yes, what diet? _____

Dietary restrictions, if any (religious/vegetarian/vegan/gluten-free/dairy-free, etc.)

_____

Describe a typical day's eating & drinking:

Breakfast: _____

_____

Lunch: _____

_____

Evening meal: _____

_____

Between meals: _____

_____

Water intake (# of glasses/day): _____ Coffee/tea: _____

What do you do for exercise and relaxation:

_____

Do you smoke? ☐Y ☐N If so, what & how many a day? _____

Do you drink alcohol ☐Y ☐N If so, what & how often? _____

Do you use recreational drugs? ☐Y ☐N If so what & how often? _____

If not now, have you in the past? ☐Y ☐N If so what? _____

Your general state of Health is: ☐excellent ☐good ☐fair ☐poor

Number of antibiotic treatments in last 5 years? _____

History of adverse reactions to immunizations ☐Y ☐N reaction? _____

Are you regularly exposed to toxins or other hazards (work/home/hobbies, etc.): please describe:

_____

How would you describe the emotional climate in your home?

_____

How stressful is your work or other aspect of your life? How do you manage the stress?

_____

List any emotional traumas/episodes, with rough dates, as far back as you like (e.g. bereavements, divorce, parents split up, abuse, etc

_____

_____

Is there anything else that you feel would be important for us to know?

_____

. . . . . .

What areas, problems or goals would you like help with now? (Please list in order of importance to you.)

_____

_____

Health Kinesiology™ is a branch of alternative medicine that incorporates bioenergetic kinesiology so that information can be gathered and monitored from the client's energy system. By using manual muscle-testing, the Health Kinesiology™ practitioner can determine what may be stressing the energy system and how to make corrections to it. Health Kinesiology™ does not directly treat or cure any disease or condition. However, Health Kinesiology™ does work to restore the natural energy balance of the meridian system. In turn, this energy balance helps to improve the health condition of the body. Therefore, anyone with any condition can benefit from the application of Health Kinesiology™.

Thank you for taking the time to fill out this lengthy intake form. We look forward to working with you to optimize your health and well-being.

Please read and sign the informed consent that follows.

Informed Consent to Treatment

***Please read and sign the following statements**:*
I understand that I give my consent to the practitioners of East House Natural Health Centre to conduct a session of Health Kinesiology™, and/or other natural therapies such as SCENAR, essences, nutritional consulting, Matrix Energetics, etc. as may be appropriate, with me.

I understand that the practitioners of this health centre are certified in their disciplines and will use only natural, non-invasive methods of assessment and therapy. I am aware that a healing reaction (commonly called "detox reaction") may occur. It is usually mild and will pass in a few days with rest and water. I may experience tiredness, irritation, digestive disturbances, soreness, a mild fever or other symptoms. If I have any concerns with a reaction I will contact my practitioner immediately.

*I also understand that Matrix Energetics and Health Kinesiology™ do **NOT directly treat** any physical diseases, disorders, ailments, etc. Matrix Energetics and Health Kinesiology™ work is for the body's underlying energy system.*

I also understand that Health Kinesiology™ is NOT psychotherapy. It deals with emotional issues on an energy level, not a conscious level. It does NOT deal with, nor is it related to parapsychology.

*I understand that Health Kinesiology™ and Matix Energetics are complementary health programs and do **NOT diagnose** disease or conditions, nor does it replace the care of your physician. It is your responsibility to consult your physician about any medical problem or concern that you become aware of.*

I understand that any advice given to me as a client at East House Natural Health Centre is not mutually exclusive from any treatment or advice I may be given by another health care provider. I understand that I am at liberty to seek, or continue, medical care from any other health care provider qualified to practice in the province. I understand that the practitioners reserve the right to determine which cases fall outside of their scope of practice and an appropriate referral will be recommended.

I understand that I am accepting or rejecting this care by my own free will. No employee or practitioner at East House Natural Health Centre is suggesting to me to refrain from seeking the advice of another health care provider.

I understand that the services offered are not covered by AHS or MSP and are payable at time of service. Submission to any insurance plan that may provide coverage for the service is my sole responsibility.

I understand the 48 hours notice is required for appointment cancelation; otherwise, I will be responsible for the cancelation fee of 50% of the time booked.

I understand that any therapies recommended will be explained to me in full by the therapist and that I will give consent to treatment based on informed consent.

☐ *I consent to receive receipts, appointment notifications, follow-up and educational emails from East House Natural Health and Check Appointments, our online booking calendar.*

I, _____, have read, understood, and agree to the above statements.

_____

SIGNATURE (or PARENTAL GUARDIAN'S SIGNATURE**)** **DATE**

Please print Parent's name if signing for a minor: _____

Print Submit