

Important Advice for Distance Healing Client's

Be advised that this Energy Healing Therapy is not a substitute for medical therapy.

Do not cease any medical treatment or medication without consulting your doctor or other health care professional.

It is advisable to avoid alcohol prior energy therapy and for some time after each therapy session.

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Be aware that in some instances there is a possibility of experiencing some minor, temporary reactions following therapy. For example, you may experience some unusual tiredness or some minor aches and pains. If you experience any or all of these symptoms, this is not unusual. Your body may be trying to unwind and relax after many years of holding it all together.

Be advised not to drive or undertake any excessive heavy or physical work or exercise, this includes sports of any kind. And be advised not to undertake any work which requires alertness to at least 6 – 8 hours following an energy healing session.

If you are driving, we recommend that you sit for at least 20 minutes before commencing to drive.

We recommend that you drink at least 2 – 3 pints of water daily between therapy sessions unless otherwise advised by the energy therapist or other health care professional.



CLIENT INFORMATION AND CONSENT FORM

FYI: an accurate health history ensures that it is safe for you to receive EMMETT Technique treatment/ Energy Therapy, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorisation is legally required before any of this information can be released.

Name:

Address:

Postal Code:

Today's date: Date of Birth:

Phone Numbers: Home: Mobile: Work:

Email Address:

Occupation:

DISCLOSURE

it is important that you fully disclose to the practitioner any of the following conditions that may the recipient may have or presently had.

- | | |
|--|---|
| <input type="checkbox"/> Heart Complaint | <input type="checkbox"/> Implants eg, breast, pacemaker, kidney |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fits or Convulsions |
| <input type="checkbox"/> Presently Pregnant | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Jaw or facial construction or surgery | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Previous or present fractures or replacements | <input type="checkbox"/> Migraine Headaches |

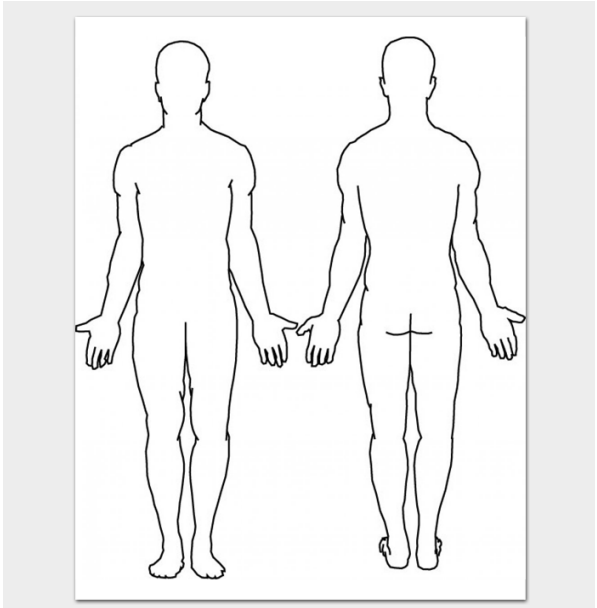
Please be assured that the information that you give is held in accordance with current Data Protection Legislation.

Doctors name:

Address of surgery:

Postal Code:

REASON FOR SEEKING TREATMENT:



On the body diagrams to the left, please circle the areas that are experiencing problems/pain/stiffness etc. If you are experiencing pain in one area and feeling it elsewhere, please indicate this with arrows.

PLEASE STATE HERE WHY TREATMENT IS BEING SOUGHT

Large empty rectangular area for writing the reason for seeking treatment.

SIGNED:

DATE: