Live Well Energy Works
Kazumi Dunn, AP, CECP
2 Straw Lane
Hicksville, NY 11801
516- 871-1928
kazumidunn@gmail.com

CLIENT INTAKE FORM

Please update me on any changes in your contact information! DATE ____________________

NAME ______________________________ EMAIL ______________________________

ADDRESS ______________________________

CITY/STATE/ZIP ______________________________

BIRTH DATE ______________________________

OCCUPATION ______________________________ REFERRED BY ______________________________

CONTACT INFORMATION: Are confidential messages OK? Yes ☐ No ☐

CELL PHONE ______________________________ HOME PHONE ______________________________

EMAIL ADDRESS ______________________________

EMERGENCY CONTACT NAME ______________________________

PHONE(S) ______________________________ RELATIONSHIP ______________________________

PLEASE READ CAREFULLY:

I understand that the Eden Energy Medicine (EEM) & Emotion Code (EC) sessions I receive are provided for the basic purpose of harmonizing my body's energies. If I experience any pain or discomfort during a session, I will immediately inform my practitioner.

I further understand that EEM & EC should not be construed as a substitute for needed medical attention. Energy Medicine practitioners do not diagnose, treat, or prescribe for medical conditions. Energy Medicine may address physical concerns by working with the electromagnetic fields that regulate the body as well as by shifting the more subtle energies described in other cultures with terms such as chakras, meridians, and etheric fields.

SIGNATURE ______________________________ DATE ______________________________

Please list the main concerns you would like us to address in our sessions, noting how long you have been dealing a specific issue, if you have been seeing a medical doctor for it, the diagnosis, if any, as well as any other treatments you have tried: ______________________________

____

____

____

Do you have a Pacemaker? ________ Do you have Metal Plates or Screws in your body? ________
Do you have Diabetes? ________ Are you pregnant? ________

FAMILY MEDICAL HISTORY

☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Seizures
☐ Asthma ☐ Allergies Other Significant Illnesses: ______________________________

YOUR MEDICAL HISTORY

☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Seizures
☐ Asthma ☐ Allergies Other Significant Illnesses: ______________________________

List any other significant illnesses/hospitalizations/surgeries (with dates): ______________________________

Describe any major accidents or traumatic events and approx. dates: ______________________________

Describe painful or distressed areas, if you haven't already. ______________________________

Medications/Supplements ______________________________

Allergies/Sensitivities (drugs, chemicals, foods, environmental, etc.) ______________________________

What gives you joy? ______________________________

How do you deal with stress? ______________________________

How do you relax? ______________________________

How do you take care of your body? ______________________________

Please note any comments or additional pertinent information. ______________________________