

**Clayton Avery**  
*Energy Healing*  
503.693.9101 • [www.rosespringscenter.com](http://www.rosespringscenter.com)

**Client Information**

**Please fill out to the best of your ability. Write N/A if not applicable.**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

List of Current Supplements: \_\_\_\_\_

\_\_\_\_\_

List of Prescribed Medications: \_\_\_\_\_

\_\_\_\_\_

Over the Counter Medications: \_\_\_\_\_

\_\_\_\_\_

Allergies / Sensitivities: \_\_\_\_\_

\_\_\_\_\_

Use: Quantity and Frequency

Caffeine: \_\_\_\_\_

Alcohol: \_\_\_\_\_

Tobacco: \_\_\_\_\_

Exercise: Type and Frequency: \_\_\_\_\_

\_\_\_\_\_

Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

Health Complaints / Concerns / Symptoms: \_\_\_\_\_

\_\_\_\_\_

Other Energy Work: Acupuncture, Chiropractic, etc. \_\_\_\_\_

\_\_\_\_\_

Consent for Care:

- I understand that my practitioner is not a licensed medical healthcare provider and therefore cannot diagnose or prescribe medications / supplements.
- I understand that the services my practitioner provides are not a substitute for medical evaluation and treatment.
- I understand that there is no implied or stated guarantee of success or effectiveness for Energy Healing sessions. It is my choice to receive Energy Healing and I give my consent for Energy Healing.
- I understand that the client practitioner relationship will be held in strict confidence.

Client Name – *please print*

\_\_\_\_\_

Client Signature – Parent or Guardian, if client is under 18 years of age

\_\_\_\_\_ Date \_\_\_\_\_

Please share a summary of the primary concern (hope/issue/desire, etc.) that brought you here today:

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Please describe what you are hoping to get out of your first session:

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In addition to the primary issue which brought you here today, what other concerns, fears, or desires would you like to address?