

CLIENT INFO

Client Name _____ Date: _____

Last

First

MI

Address _____

Phone _____ Email _____

Marital Status _____ Occupation _____ Birth Date _____

HEALTH INFO

Have you had any of the following? Please check all that apply.

- | | | |
|--------------------------------------------|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Physical Traumas |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnant Now? |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Other: Present Pains |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other: Not listed above |

Notes/ Explanations/Surgeries: Please give any additional details for checked items above, including treatments for diseases or conditions, approximate dates, etc, and **surgeries:**

Are you now under the care of a physician for any condition? Yes No

If yes, please explain: _____

Date of last physical: _____

Siblings & Their Ages _____

Deaths in Family or other Loved Ones _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Please list all drugs, herbs and/or health supplements that are being taken, and how frequently:

Signature: _____

CLIENT RESPONSIBILITY AGREEMENT

VortexHealing® Divine Energy Healing is a very powerful healing art. Therefore, it is to be expected that various situations can arise from studying or practicing this healing art. Certain problems, either physical or emotional, may be alleviated. Deep mystical experiences can occur, as well as life-change realizations. But sometimes, suppressed emotions or physical tensions may receive enough healing energy to be pushed to surface, so they can be released or resolved, and this process may create various emotional or physical symptoms. Deep healing is a process that is *intended* to create changes in one's life, and those changes can manifest physically, emotionally and spiritually. It is all part of the healing process.

I agree that I have read and understood the above paragraph and agree that the VortexHealing® practitioner is not responsible for any individual symptoms that may arise as a result of receiving VortexHealing treatments. I agree to take personal responsibility for whatever physical or emotional symptoms may arise as part of the healing process of receiving VortexHealing® treatments, as well as to take responsibility for seeking medical treatment when I perceive it is necessary.

I understand that my VortexHealing practitioner is neither a medical professional nor a psychotherapist (unless he/she also holds such degrees) and that he/she is practicing neither medicine nor psychotherapy. Although my VortexHealing practitioner may comment on the nature of body energetics and consciousness in relation to disease and mental health, it is understood that these comments are not intended as advice for any course of action for any medical or mental health issues that I may have. I understand and agree that VortexHealing® treatments do not take the place of medical treatment or evaluations, when needed.

Although VortexHealing® Divine Energy Healing may help me significantly with whatever my situation is, I recognize that not everyone can be helped with energy healing. Therefore, I understand that any payments for sessions are not for any specific results but for the time the practitioner takes with me. I agree that I am liable for payment of any scheduled appointment unless I give notice of cancellation at least 24 hours beforehand.

Client's Signature: _____

Sign Name

Print Name

Date

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