Firefly Holistic Healing

Client Information and Consultation Form

Date: _____

Name: _____ Date Of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Contact Phone: _____ Marital Status: Single____ Married ____

Referred By: _____ E-mail Address (optional)_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____

Relationship: _____ Phone: _____

Activities/Hobbies: _____

Date Last Participated in Activity/Hobby: _____

Have you ever had energy work? **YES NO** Massage? **YES NO** Date of Last appt:_____

Primary Reason for this Appointment: _____

_____

Do you have any conditions that your practitioner should be aware of? **YES** **NO**

Explain: _____

Are you taking any medications, supplements or herbal treatments? **YES** **NO**

Explain: _____

Are you under the care of a health of mental health care practitioner? **YES** **NO**

Name/Phone/City: _____

Name/Phone/City:_____

_

Please Check the Appropriate Answer

Do You:	YES	NO	Explain
Wear contacts or dentures?	☐	☐	_____
Have skin issues or allergies?	☐	☐	_____
Have digestion issues?	☐	☐	_____
Have heart/circulatory/diabetic issues?	☐	☐	_____
Have Spinal issues/joint pain?	☐	☐	_____
Have a contagious condition?	☐	☐	_____
Have restricted movement?	☐	☐	_____
Drink more than 1 quart water daily?	☐	☐	_____
Exercise?	☐	☐	_____
Drink carbonated beverages?	☐	☐	_____
Other:			
What was your breakfast & lunch?	☐	☐	_____
Have any emotional distress?	☐	☐	_____
Have any work related stress?	☐	☐	_____
Most difficult task in your day?	☐	☐	_____
Any surgery/Injuries?	☐	☐	_____
Memory loss,confusion, overwhelmed?	☐	☐	_____

OVER →

Do you have or are you any of the following (C) Current or (P) Past:

Pregnant		Cancer		Anxiety		Degenerative Disks	
Diabetes		Varicose Veins		Depression		Headache/Migraine	
Smoke		TMJ		Seizures		Frequent headaches	
Dizziness		Chronic pain		Scoliosis		Tingling in extremities	
Epilepsy		Nausea		Dementia		High/low blood pressure	

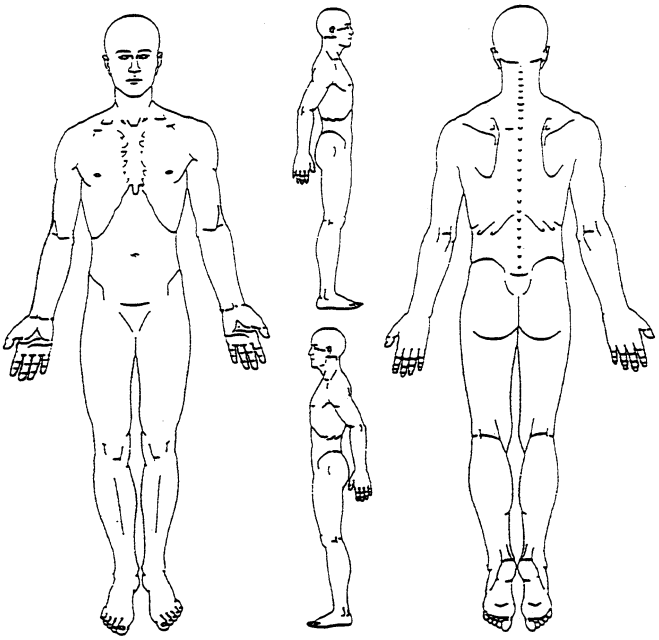
Please list anything else that your practitioner should know:

_____

_____

_____

On the diagram below, please circle the areas of the body that you feel need the most attention in the energy session:



Describe any other concerns or areas you would like for me to avoid:

_____

_____

Terms and Conditions

I understand that massage/energy work is not a replacement for medical care and that no medical diagnosis will be made. Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all known medical conditions and will keep the therapist updated as to any changes in my medical condition going forward. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort.

With this in mind, I agree to receive energy consultations/massage and hold the practitioner blameless for any problems that might arise as a result of this session.

24 HOUR CANCELLATION POLICY
Should I cancel or miss an appointment with less than 24 hours notice, I authorize Kristy Kostelecky to charge my VISA/MC/Amex/Discover Card or checking account for the full session fee.

E-MAIL POLICY
I may use your e-mail address for appointment reminders, promotions and news from Kristy Kostelecky (Firefly Holistic Healing). Your privacy is important. I will not sell, rent, or give your name or address to anyone.

Signature: _____ Date: _____