Margarette Shelton, OTR, PhD, LMT, EEM-CLP
BodyWorks for BodyEase
281-216-1244
www.bodyworksforbodyease.com
margarette888@bodyworksforbodyease.com

TX #128551 IN #MT21304812

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: _____ PHONE: _____

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

EMERGENCY CONTACT NAME: _____

PHONE(S): _____ RELATIONSHIP: _____

PLEASE LIST THE NAME and specialties of other health care professionals you are currently seeing, as well as the name of your primary physician and approximate date of your last physical exam:

_____

PLEASE READ CAREFULLY:

I understand that Eden Energy Medicine, CranioSacral Therapy, Graston technique, Remote work, or any combination of modalities I receive are provided for the basic purpose of harmonizing my body's energies, releasing tightness in tissues, relieving stress, or providing relaxation. If I experience any pain or discomfort during a session, I will immediately inform my practitioner and she will stop.

I further understand that none of these modalities should be construed to be a substitute for needed medical attention. Margarette Shelton, OTR, PhD, LMT, EEM-CP does not diagnose illness, disease, or any other physical or mental disorder. In addition, she does not prescribe medical treatment or pharmaceuticals. The modalities she uses bring about physical improvements by releasing tissues known as fascia; at times, the client may experience an emotional release as well. Energy Medicine brings about physical and/or emotional improvements by impacting 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.

What do you hope to gain from your (Check all that apply) Eden Energy Medicine ☐

CranioSacral Therapy ☐ Graston ☐ Remote ☐ session(s)?

Describe problems you wish to address. Include how long you have had them, any medical diagnosis for them, treatments you have tried, and their effectiveness:

In a few words, please describe your goal for our work together.

Are you aware of any emotional distress from an injury or trauma? Please explain:

Have you suffered any form of abuse your body may be holding? (Please explain as much as you are comfortable, keeping in mind that everything here is held in strict confidence).

Do you have a Pacemaker or other implant? YES ☐ NO ☐

Do you have Metal Plates or Screws in your body? YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐

Do you have cataracts? YES ☐ NO ☐ Date(s) of surgery: _____

Do you wear contact lenses? YES ☐ NO ☐

Do you wear dentures? YES ☐ NO ☐

Have you had extensive dental work (i.e., braces, crowns, root canals, scraping, implants, etc.)? YES ☐ NO ☐

Nature of dental work: _____

YOUR MEDICAL HISTORY (please check all that apply)

Cancer ☐ **High Blood Pressure** ☐ **Heart Disease** ☐ **Stroke** ☐

Seizures ☐ **Asthma** ☐ **Covid-19** ☐ **Allergies** ☐ **Spinal Cord Injury** ☐

Other Significant Illnesses or Neurological Conditions:

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

Allergies (drugs, chemicals, foods, airborne allergies, etc.):

Please list: Current Nutritional and Herbal Supplements and Their Purposes (use back if necessary):

Please check if you consume or use and indicate what kind and how often:

☐ Alcohol Kind:_____ Frequency: _____

☐ Caffeine/Coffee Kind: _____ Frequency: _____

☐ Soda Kind: _____ Frequency: _____

☐ Cigarettes/Tobacco Kind: _____ Frequency: _____

☐ OTC Medications Kind: _____ Frequency: _____

All answers on this form are confidential. However, if substance-use appears to be *life threatening*, I am required by law to report it. Please check all that apply, including when last used, frequency per day/week, and any adverse reaction.

	Last Used	Frequency of Use	Adverse Reaction	
☐ Marijuana	_____	_____	Yes ☐	No ☐
☐ Amphetamines	_____	_____	Yes ☐	No ☐
☐ Cocaine	_____	_____	Yes ☐	No ☐
☐ Other: _____				
Other continued	_____	_____	Yes ☐	No ☐

DO YOU HAVE HIGH ☐ MEDIUM ☐ LOW ☐ STRESS DAYS?

HOW DO YOU DEAL WITH STRESS?

WHAT GIVES YOU JOY?

HOW DO YOU RELAX?

HOW DO YOU TAKE CARE OF YOUR BODY?

ARE THERE ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS?

Please read and initial:

_____ I understand the therapist does not diagnose illness, disease or any other physical or mental disorder. In addition, the therapist does not prescribe medical treatment or pharmaceuticals.

_____ I am not currently experiencing any of these conditions: (within the last 6 months): injury to the head and/or neck; any fracture to the base of the neck, concussion, or hemorrhage.

_____ I am aware that the modalities the therapist uses are not a substitute for medical examination and/or diagnosis and that it is recommended I see a physician for any physical ailment or mental health concern I might have.

_____ Because the therapist must be aware of existing physical and mental/emotional conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and/or undisclosed conditions.

SIGNATURE: _____ **DATE:** _____