Medical / Health Intake Form

Provided by: Angela Waterlight

Name ……..

Occupation ……

Address ……

Town …….. **Zip code** ……..

Email ……

Gender Pronouns ……..

Date of Birth ……

Marital Status ……

Religious Background ……

Phone Number ……

Reason for visit …… ……

……

Please list symptoms of importance to you……

……

To give us a complete picture of your health and lifestyle, please complete the following questionnaire

Mark with a ✓ where applicable to yourself or ◯ circle if your family has a history or (✓) for both

Condition		Condition		Condition	
Allergies/Eczema		High blood pressure		Thrombosis or Phlebitis	
Asthma		Low blood pressure		Depression	
Hay fever/sinusitis		Cancer		Anxiety	
Diabetes		Thyroid problems		Psychological conditions	
Migraines/Headaches		Heart problems		Alcoholism	
Epilepsy		Pregnancy		Digestive and/or intestinal problems	
Urinary/Kidney problems		Hepatitis/HIV/AIDS		Other	
Skin conditions		Cold hands/feet		Dislocations, breaks/fractures	
Obesity		Dizziness/blurred vision		Joint pain, arthritis, rheumatism	
Menstrual problems					

Medications and Supplements: Are you currently taking any medications? Yes / No

If yes, please provide details

Are you currently taking any herbal or vitamin/mineral supplements? If yes, please provide details

Have you had any illness or operations within the last 12 months? If yes, please provide details

Angela Grace Waterlight
RN, LMT, Certified Energy & Stone Medicine Practitioner, Meditation Coach, Intuitive Counselor
angelawaterlight.com | angelawaterlight@gmail.com | 1-631-255-2781

Current Medical Conditions: *Briefly state any current medical conditions and tick the boxes that apply*

Allergies		Bleeding Disorder		Epilepsy		Heart Conditions	
Cancer		Infection		Diabetes		Pacemaker	
Pregnancy		Other					

Please ✓ if you have any of the following:

IMMUNE		LIVER / GALL BLADDER		METABOLIC	
Colds/Influenza		Hives		Fatigue	
Allergies/Hay fever		Itching		Weakness	
Frequent Infections		Stools pale/clay color		Dry skin/brittle hair	
Thrush		History of jaundice, Hepatitis		Weight gain	
SKIN		**URINARY**		Sensitive to heat	
Skin Problems		Frequent urination		Sensitive to cold	
Poor wound healing		Poor stream		Cold hands and feet	
ENT		Dribbling urine after urination		Craving frequent snacks/sugar	
Ear Infections		Sudden, urgent need to urinate		Muscle cramps	
Tonsillitis		Leakage with cough/strain		Migraine	
Sinusitis		Getting up at night to urinate		**MUSCULOSKELETAL**	
RESPIRATORY		Frequent bladder infections		Aches/pains	
Cough		**REPRODUCTIVE (MALE)**		Joint pain	
Wheeze		Poor beard/hair growth		Joint swelling	
Breathlessness		Difficulty sustaining erection		Joint stiffness	
CARDIOVASCULAR		Lack of sexual desire/interest		Headaches	
Chest pains		Past sexually transmitted disease		**NERVOUS SYSTEM**	
Palpitations		**REPRODUCTIVE (FEMALE)**		Tingling/numbness	
Breathless with exertion		Cycle length (days)		Vertigo	
Dizziness		Period length (days)		Poor balance	
Ankle swelling		Miss periods?		Recent change in vision	
Varicose veins		Pain with/before period		Morning headaches	
Leg pain with exertion		Fluid retention with/before period		**MENTAL**	
Cold feet		Heavy periods		Frequent sad feelings	
Easy bruising		Hot flushes		Feelings of anxiety / panic	
UPPER GASTROINTESTINAL		Vaginal dryness		Loss of interest / enjoyment	
Indigestion		Recurrent thrush		Reduced / broken sleep	
Belching/burping		History of sexually transmitted disease		Difficulty concentrating	
Heartburn/Acid reflux		History of abnormal PAP smears		Change in appetite	
Sense of fullness after food		Ovarian cysts/breast lumps		Pessimistic / guilty thoughts	
Nausea/Vomiting		Fibroids/Endometriosis		Thoughts / plans for suicide	
Stomach pain		Excess facial hair/acne		Feelings of resentment	
LOWER GASTROINTESTINAL		Lack of sexual desire/interest			
Lower abdominal pain		Milk production (not breast feeding)			
Excess gas/bloating					
Stools hard/dry					
Use laxatives					
Stools loose/watery					
Blood/mucus in stools					

COMMENTS:

LIFESTYLE: **Please answer yes (Y) or No (N) to the following and how much (quantify daily and/or weekly)**

Do you drink?	Y/N	How much?	Do you smoke?	Y/N	How much?
• Coffee			• Tobacco		
• Tea			• Recreational Drugs		
• Soda			**Do you have a**	**Type** [ex. yoga, meditation, exercise]	**How often?**
• Alcohol			• Self Care Practice		
• Water			**Rate what you think your stress level is**		***Score 1–10***

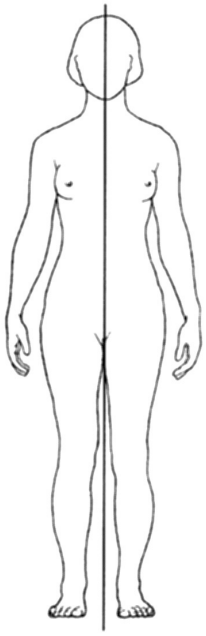
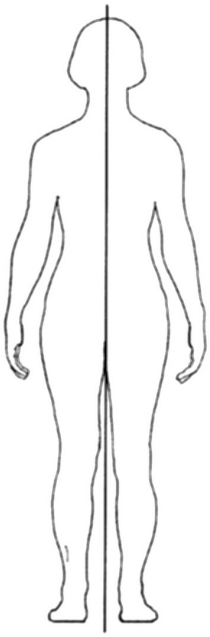
DIET: ***Please indicate your general diet in the table below***

MEAL TIME	Solids	Liquids
Breakfast		
Mid morning		
Lunch		
Mid afternoon		
Dinner		
Snacks/Deserts		

What do you hope to gain from this treatment?

Is there any other information you wish to share that may be relevant to this treatment?

PHYSICAL PAIN OR DISCOMFORT Please ✓ relevant boxes and describe the pain in each area, years experienced, if pain is result of injury etc.		
Neck & Shoulders		
Upper Back		
Lower Back		
Knee & Feet		
Elbows & Hands		
Any other pain		
Client Comments		

Please indicate any areas of pain or discomfort			
			
Anterior Right - Left	Posterior Left - Right	Lateral Left	Lateral Right

REFERRAL INFORMATION Please ✓ relevant box				
INTERNET		**PERSONAL**		**OTHER / DETAILS**
Natural Therapy Pages		Health & Wellness Centre		
Other Internet		Friend		

IMPORTANT PATIENT INFORMATION

If you are taking prescription medication and/or receiving other therapies – please ask your doctor what treatments and supplements you may be receiving. Do not alter or cease medication without asking the prescribing practitioner. This includes psychological therapies. Therapies offered at my centre balance energy only, this does not include diagnosis of disease or other conditions. In accordance with the Privacy Act 1988, all client information is private and confidential.

Consent: I, the undersigned, hereby state that all the above information is true and correct to the best of my knowledge. No liability: We have no liability to you or any other person for Health complaint(s) or injury incurred, for whatever reason, by the undersigned, as a result of receiving Soul Therapy, Energy Medicine, Ancient Stone Alignments, Intuitive counseling or Meditation services through Angela Grace Waterlight, during the period of attendance on these premises.

Signature:_____ Date: _____

COMMITMENT AND CANCELATION AGREEMENT

Please keep in mind that working with me is a partnership and a commitment is essential in order to see positive shifts in your physical, mental, and emotional life. The time and energy you are willing to put into addressing your issues will be reflected in the outcome of the work we will do together. You will be given a weekly appointment time that is mutually agreed upon by you and Angela Grace Waterlight. This time will be held for you alone, and you are asked to make every effort to attend your sessions as scheduled.

PAYMENT POLICY: Please pay the fee for your session at the time of service, unless other arrangements have been made prior to the session.

CANCELLATION POLICY: Should you have to cancel or reschedule your appointment, please contact me by telephone only, no later than 24 hours prior to your appointment. Cancellations made LESS than 24 hours in advance or missed appointments will be charged in full. Please understand that the time slot cannot be filled without appropriate notice of cancellation

Signature:_____ Date: _____