Redbird & Rabbit Energy Medicine, LLC

Amy Bacchieri, Certified EEM Practitioner

GENERAL INFORMATION:

DATE	
NAME	
ADDRESS	**STREET:**
	CITY, STATE, ZIP:
DOB	
OCCUPATION	
REFERRED BY	

CONTACT INFORMATION:

HOW DO YOU PREFER TO BE CONTACTED?	**Circle One:** EMAIL PHONE CALL TEXT
ARE CONFIDENTIAL MESSAGES OK?	**Circle One:** YES NO
*(*Please indicate if confidential messages should not be left at any of the following.)*	
PREFERRED EMAIL	
PHONE NUMBER	**HOME:**
	CELL:
EMERGENCY CONTACT	**NAME:**
	PHONE(S):
	RELATIONSHIP:

WELLNESS/SESSION GOALS:

GENERAL ASSESSMENT How would you describe your overall sense of wellness–both mentally and physically?	
PRIMARY GOAL? *What would you most like to get out of our sessions together?	
SECONDARY GOAL(S)? *What would you consider to be secondary goals for our sessions?	
SPECIFIC ISSUES *List any physical, mental, or spiritual issues you wish to address. Please include the following information: ● how long you've had these issues ● whether or not you've been given a specific diagnosis for these issues ● other treatments you've tried and how well they worked	

HEALTH INFORMATION & HISTORY:

PRIMARY CARE PHYSICIAN	**NAME:**
	PHONE NUMBER:
	APPROXIMATE DATE OF LAST EXAM:
OTHER HEALTHCARE AND/OR HOLISTIC PRACTITIONERS *Please list the name and specialities of other healthcare and/or holistic practitioners with whom you are currently working.	**1.**
	2.
	3.
	4.
	5.

CURRENT MEDICAL INFORMATION:

DO YOU HAVE ANY OF THE FOLLOWING:	*** Please Circle either yes or no.**	*** Please include any relevant information if applicable.**
➔ **PACEMAKER**	**YES NO**	
➔ **METAL PLATES OR SCREWS**	**YES NO**	
➔ **HEARING AIDS**	**YES NO**	
➔ **DIABETES/INSULIN PUMP**	**YES NO**	
➔ **KIDNEY DISEASE**	**YES NO**	
➔ **HYPER/HYPO THYROID DISEASE**	**YES NO**	
➔ **HIGH BLOOD PRESSURE**	**YES NO**	
➔ **CIRCULATION ISSUES**	**YES NO**	
➔ **CANCER, RADIATION TREATMENTS, CHEMOTHERAPY**	**YES NO**	
➔ **EPILEPSY OR SEIZURE DISORDER**	**YES NO**	
➔ **AUTOIMMUNE DISEASE(S)**	**YES NO**	
➔ **ASTHMA**	**YES NO**	

➔ **MENTAL ILLNESS**	**YES NO**	
➔ **OTHER SIGNIFICANT ILLNESS OR DISEASE**	**YES NO**	
➔ **ARE YOU PREGNANT OR TRYING TO CONCEIVE?**	**YES NO**	.

MEDICAL HISTORY:

	*** Please Circle either yes or no.**	*** Please include any relevant information if applicable.**
ANY MAJOR ILLNESSES, SURGERIES, OR ACCIDENTS, INCLUDING CHILDHOOD ILLNESSES?	**YES NO**	*Please include approximate dates if possible.
ANY TRAUMATIC EVENTS NOT INCLUDED IN THE PREVIOUS QUESTION?	**YES NO**	*Please include approximate dates if possible.
ANY HISTORY OF ALLERGIES, CHEMICAL, DRUG, HERBAL, OR FOOD SENSITIVITIES?	**YES NO**	

ANY HISTORY OF STROKES OR ANEURYSMS?	**YES**	**NO**	
ANY HISTORY OF MENTAL ILLNESS (IN THE PAST, NOT CURRENT)?	**YES**	**NO**	
ANY HISTORY OF EATING DISORDERS?	**YES**	**NO**	
ANY HISTORY OF DIGESTIVE ISSUES?	**YES**	**NO**	
ANY HISTORY OF HEADACHES?	**YES**	**NO**	
ANY HISTORY OF SINUS ISSUES?	**YES**	**NO**	
ANY HISTORY OF INFECTIONS?	**YES**	**NO**	
ANY HISTORY OF SKIN ISSUES OR DISORDERS?			
OTHER?	**YES**	**NO**	.
FAMILY HISTORY ***Please list any major diseases/conditions that run in your family if applicable.**			

CURRENT MEDICATIONS AND SUPPLEMENTS:

*Please list anything you are currently taking.

NAME	PURPOSE	HOW OFTEN & HOW LONG?	ADVERSE REACTIONS?

LIFESTYLE INFORMATION I:

*All information in this form is confidential; answers are for information purposes only.	* Please Circle either yes or no.	AMOUNT/FREQUENCY? (IN GENERAL)	ADVERSE REACTIONS?
DO YOU DRINK ALCOHOL?	YES NO		
DO YOU CONSUME CAFFEINE?	YES NO		
DO YOU DRINK SODA?	YES NO		
DO YOU SMOKE/USE TOBACCO PRODUCTS?	YES NO		
DO YOU USE MARIJUANA?	YES NO		
DO YOU TAKE OTHER NON-PRESCRIPTION DRUGS?	YES NO		

LIFESTYLE INFORMATION II:

SLEEP *How is your sleep quality, and how many hours per night do you sleep on average?	
MOVEMENT *Do you exercise regularly? If so, describe what you do for movement/exercise.	
ENERGY LEVEL *How would you describe your baseline energy level?	
DIET NUTRITION *How would you describe your diet and nutrition habits? Do you follow a strict eating philosophy or regiment? Crave sugar/carbs?	
WATER *What is your daily water intake? Are you often dehydrated?	
STRESS *How would you describe your overall stress level? How well do you handle stress? How do you manage stress?	
PLEASURE *What do you do for fun/hobbies? How do you relax or unwind?	
JOY *What would you say gives you joy?	
OTHER *Is there anything else you would like to tell me that hasn't been addressed in this intake form?	

PLEASE READ CAREFULLY AND SIGN THE FOLLOWING:

I waive any liability towards Amy Bacchieri or Redbird and Rabbit Energy Medicine, LLC, that may arise due to any omission or misrepresentation of my health**.**

Signature: _____

Printed Your Name:_____ Date: _____