Energy Healing Form

Alexandria Myotherapy, Inc.
333 North Fairfax Street, Suite 303
Alexandria, VA 22314
(703) 548-2270

Name: _____ Date: _____

Phone: Home (____) ____ – ____ Date of Birth: _____

Cell (____) ____ – ____

Have you had prior energy healing? _____ If yes, when was your last session? _____

Reasons for Session

☐ Relaxation and stress reduction ☐ Specific issue

Physical Issue:

Emotional Issue:

Mental/Spiritual Issue:

Changes since last session:

Pre-Assessment

Please complete this short questionnaire before your session by rating yourself on each of the following four categories.

1 = None 10 = High Level

Rate your current level of PAIN

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Rate your current level of STRESS

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Rate Your current level of ANXIETY (persistent worry, fear or apprehension)

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Rate your current level of DEPRESSION

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

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CLIENT AGREEMENT

I am aware that when I make an appointment, the scheduled time is reserved for me, and should I cancel with less than 24 hours' notice, I am responsible for payment in full. I understand, too, that if I am late for an appointment, the therapist may not be able to give me a full session, though I am responsible for the full charge.

I understand that massage is not a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any physical or mental ailment of which I am aware. I understand that the massage therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. I also understand that the employees of Alexandria Myotherapy, Inc. have access to my records. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist informed of any changes in my medical condition and understand that there shall be no liability on the therapist's part should I neglect to do so.

I agree to let the therapist know whether any procedure is causing me discomfort, whether from pressure, heat, or any other cause. I understand that failure to do so may cause me harm, and there shall be no liability on the therapist's part if I fail to communicate my discomfort.

☐ **I agree to pay for any appointments I fail to keep without giving 24 hours notice.**

☐ **I have read and understand the policies and fee schedule and testify that the information I have provided is true.**

_____ _____

Signature Date

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Please keep this in your glove compartment and place it in one of your windows when you park in the garage, which is permitted only on weekends or after 5:30 weekdays.

Please note: *On occasion there is a parking company that takes over the garage on weekends, and then you will need the visitor pass to avoid paying a parking fee.*

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V I S I T O R

to

Alexandria Myotherapy, Inc.

Suite 303

703-548-2270

Valid only weekdays after 5:30 p.m.
and on weekends