Kristy Kostelecky
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: ____
City: __________________________________ Phone: ___________________________

Please Check the Appropriate Answer

Do You:	**YES**	**NO**	**Explain**
Wear contacts or dentures?	☐	☐	
Have skin issues or allergies?	☐	☐	
Have varicose veins?	☐	☐	
Have heart/circulatory/diabetic issues?	☐	☐	
Have Spinal issues?	☐	☐	
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 item in your day?	☐	☐	
Any major surgery?	☐	☐	
Any recent or past injuries?	☐	☐	

OVER →

Do you have or are you any of the following:

Pregnant	☐	Cancer	☐	Anxiety	☐	Chronic pain	☐
Smoker	☐	TMJ	☐	Seizures	☐	Frequent headaches	☐
Epilepsy	☐	Nausea	☐	Dementia	☐	High/low blood pressure	☐

Do you have any other concerns, medical conditions, illnesses, broken bones, or accidents that your practitioner should know about?

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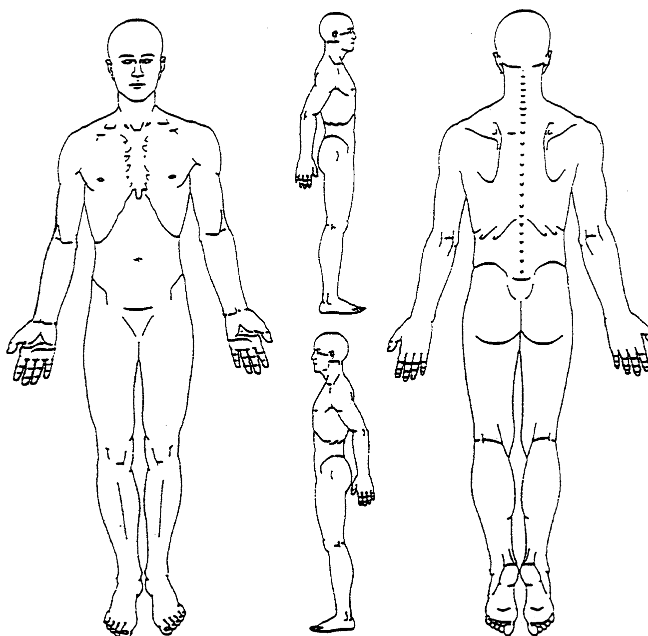
On the diagram below, please circle the areas of the body that you feel need the most attention in the energy session:



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

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PLEASE READ THE FOLLOWING STATEMENTS THEN SIGN AT THE BOTTOM OF THE PAGE.

I understand that the consultation given here is for the purpose of improving energy flow. I understand that the practitioner does not diagnose illness, disease, or any other physical or mental disorder. The practitioner does not prescribe medical treatment of pharmaceuticals, or perform spinal manipulation. I understand that energy consultation/massage is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see an appropriate health care provider for any physical ailment that I might have.

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.

Signature: ____ Date: ____________________