



Natural Gifts Holistic Center, LLC  
 Client Intake Form  
 for  
 Coaching & Energy Therapies  
 Please turn off or silence your cell phone



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number(s): Home: ( ) \_\_\_-\_\_\_\_ Work: ( ) \_\_\_-\_\_\_\_ Cell: ( ) \_\_\_-\_\_\_\_  
 E-Mail Address: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Preferred Method of Contact: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**General & Medical Information:**

Age: \_\_\_\_\_ ( ) Male ( ) Female ( ) Married/ with Partner ( ) Single  
 What service are you here for today? ( ) Coaching ( ) Energy Therapy ( ) Other \_\_\_\_\_  
 Is this your first time for coaching or energy services? ( ) Yes ( ) No

Client prefers: Tues. Wed. Thurs. Fri. Sat. \_\_\_ a.m. \_\_\_ p.m. \_\_\_ after 5:00pm  
 Every week Every 2-weeks Every 3-weeks Once a month

Are you interested in adding aromatherapy to your session for an additional \$10 each?  
 ( ) Yes, that would be wonderful  
 ( ) Yes, but not today, but please ask me next time  
 ( ) Not today, but I will think about it for future appointments  
 ( ) Don't think I'll ever be interested, but will let you know if I change my mind

A pleasant mixture of Lavender and Chamomile will be used in all Aromatherapy unless otherwise specified. If you would like more benefits from the different oils, then please speak with one of our Certified Aroma-therapists.

**Please take a moment to carefully read the following information and sign where indicated.**

Please circle one: Hours per day of computer use: 1-2 3-6 7+

Current Stress Level: ( ) MILD ( ) MODERATE ( ) SEVERE Is it: ( ) ACUTE ( ) CHRONIC

In which areas of your life would you like to improve, develop, or rebalance?

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**Medical History:**

- ( ) Yes ( ) No Do you suffer from epilepsy or seizures?
- ( ) Yes ( ) No Do you have any allergies? \_\_\_\_\_
- ( ) Yes ( ) No Do you have skin problems? \_\_\_\_\_
- ( ) Yes ( ) No Do you have chronic fatigue, low energy or lethargy??
- ( ) Yes ( ) No Do you have diabetes?
- ( ) Yes ( ) No Do you experience frequent headaches?
- ( ) Yes ( ) No Do you suffer from joint issues?
- ( ) Yes ( ) No Do you have a contagious disease?
- ( ) Yes ( ) No Do you bruise easily?
- ( ) Yes ( ) No Have you been diagnosed with cancer?
- ( ) Yes ( ) No Do you suffer from insomnia?
- ( ) Yes ( ) No Do you experience muscle spasms or cramps?
- ( ) Yes ( ) No Do you have any endocrine or hormonal issues?
- ( ) Yes ( ) No Do you suffer from upper back pain?
- ( ) Yes ( ) No Do you suffer from back pain?
- ( ) Yes ( ) No Do you have any current infections or illnesses?
- ( ) Yes ( ) No Do you have cardiac or circulatory problems?
- ( ) Yes ( ) No Do you have PCOS, endometriosis or other reproductive issue?
- ( ) Yes ( ) No Do you have cancer?
- ( ) Yes ( ) No Do you have osteoporosis?
- ( ) Yes ( ) No Have you had any recent sprains or strains?
- ( ) Yes ( ) No Do you have neck problems?
- ( ) Yes ( ) No Do you have HIV or other immune suppressing disease?
- ( ) Yes ( ) No Are you Pregnant? How far along? \_\_\_\_\_
- ( ) Yes ( ) No Do you have high/ low blood pressure? On Medication? \_\_\_\_\_
- ( ) Yes ( ) No Have you had surgery recently? Where? \_\_\_\_\_
- ( ) Yes ( ) No Do you have an auto-immune disease? \_\_\_\_\_
- ( ) Yes ( ) No Do you have arthritis, osteoarthritis, or rheumatoid arthritis?
- ( ) Yes ( ) No Have you had a stroke or heart attack? How long ago? \_\_\_\_\_
- ( ) ( ) Yes ( ) No Do you have numbness or stabbing pain anywhere? \_\_\_\_\_
- ( ) Yes ( ) No Is there any other physical condition I should be aware of? \_\_\_\_\_

**AVAILABLE DISCOUNTS:**

Free 15 minute initial consultation for new clients

Free 15 minute Bio-Mat Infrared Ionic Therapy with Frequent User Card

**GIFT CERTIFICATES AVAILABLE**

Family history of disease: \_\_\_\_\_

List of current medications, vitamins, supplements: \_\_\_\_\_



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Please understand that a Holistic Life and Wellness Coach **is not a licensed medical doctor or therapist**. This consultation/session is not meant to diagnose or treat any disease, but rather it is intended to provide information that will promote the conditions under which natural healing skills and abilities are strengthened. It is designed to give insights into innate healing potential and guide toward a more healthy and balanced lifestyle. I also realize that the sessions are for increasing coping skills, teaching how to manage stress in creative, healthy ways and to help eliminate unhealthy habits.

Because hypnosis / energy work should not be performed under certain medical conditions, please affirm that you have stated all known medical conditions, and have answered all questions honestly. A referral from your primary care provider may be required prior to services rendered. You agree to keep the practitioner updated as to any changes in your medical profile and understand that there shall be no liability on the practitioners part should you forget to do so.

I certify that my participation is of my own free will and I accept complete responsibility for my well being at all times. **I further certify that I am a healthy individual and that I am physically and psychologically fit to fully participate**, and I know of no reason, nor have I been informed by my physician or psychologist of any reason, why my participation would do me harm of any nature. I agree to release and hold harmless Natural Gifts Holistic Center LLC and any of its service providers from any claim arising out of any portion of these sessions in which I am voluntarily participating, including any claim for physical and/or mental injury to myself, whether caused by negligence or otherwise. I also understand that although these sessions may raise emotional issues, they are not intended to provide a therapeutic environment or be a substitute for ongoing counseling or psychotherapy. Resolution of any issues which may surface and which may warrant counseling will be my sole responsibility and will be undertaken at my sole discretion and at my own expense. I am clear that I am not being treated for specific medical problems.

Sessions begin and end at scheduled times. Any session started late due to the client arriving late, will end at the appointed time and are charged at the full rate. If cancellation of any session is necessary, please give an appropriate 24 hr. notice. Otherwise, you will be charged for the full price of the appointment. Emergency cancellations are determined at the therapist's discretion. In consideration of the next client, all sessions will end on time. If you feel you need more time, then please talk to the practitioner about coming in sooner or scheduling a longer session in the future. If you choose to not put a credit card on file, you will not be allowed to reschedule until all payments are caught up.

Accepted forms of payment: Cash, Personal Check, Visa, MasterCard, Discover Card, American Express, Gift Certificates, Living Social Voucher

Client/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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If using a credit card, please fill out the following: (this will also be the card that is charged for not showing for an appointment or for cancellation within 24 hrs.)

Please circle one: Visa   MasterCard   Discover Card   American Express

Number: \_\_\_\_\_ Zip Code: \_\_\_\_\_

3-Digit: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

\* I agree to the above terms and conditions for using this card:

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Cancellation Policy**

Out of respect for your therapist and other clients, our 24-hr cancellation policy is in full effect. Emergency cases will be dealt with individually; please view the following chart concerning our 24-hr cancellation policy.

<u># of Hours Prior to Appointment</u>	<u>Fee</u>
0 - 3	Cost of Service + \$20 scheduling fee
3.01 - 12	Cost of Service
12.01 - 24	½ of Cost of Service
24 +	No Fee

Gift Certificates, Monthly Specials, and coupon will not count towards the fees. Fees must be paid by cash, check, or credit card, for the full amount.

All fees will need to be paid prior to your next appointment. If no-shows or late cancellations happen more than two times, you may be asked to pay for your session at the time the appointment is made.

Please call if you have any other questions or concerns. 281-813-9710

Thanks  
 Zada McGuire  
 owner/ management



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By signing below, you agree to the above statements and are fully aware of the fees that will take place if cancellation of a session happens with less than 24 hr. notice. You are also consenting that your credit card will be charged accordingly if you do not show for a scheduled appointment or cancel with less than 24 hrs. You agree and realize that new appointments may be rejected or not scheduled until all payments are caught up.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_