|  |  |
| --- | --- |
| NAME:  | DATE OF BIRTH & AGE : |
| EMAIL ADDRESS :  | PHONE NUMBER : |
| How did you hear about Reconnective Healing / who referred you?  | SUBERB: | OCCUPATION: |
| Relationship status: | Children (Names & Ages): |

Appointment Date :

|  |  |
| --- | --- |
| What has urged you seek a session? |  |
| What is going on for you in your life right now? |  |
| Briefly, what is the story that you tell when describing your life to now? |  |
| What is your focus for this appointment? |  |
| Describe your outcome.  |  |
| If you could change three things going forward, what would they be? |  |
| We constantly talk to ourselves inside our heads. What are the main mind-topic and phrases that pass through your mind each day. What is the theme? |  |
| What has urged you seek a session? |  |
| What is going on for you in your life right now? |  |
| What is your focus for this appointment? |  |
| What do you feel is your Life Purpose? Do you feel you are aligned with it? |  |
| If you could change three things In your Self or your Life going forward, what would they be? |  |
| We constantly talk to ourselves inside our heads. What is the story and main phrases that pass through your mind each day, what is the theme? |  |

**PLEASE RATE OUT OF TEN – 1 = low / 10 = high.**

|  |  |  |
| --- | --- | --- |
| **Please rate your:** | **0-10** | **Comments** |
| Energy levels  |  |  |
| Stress |  |  |
| Anxiety |  |  |
| Depression |  |  |
| Melancholy |  |  |
| Sleep quality |  |  |
| Average hours of sleep |  |  |
| Number of times you wake |  | What time/s do you wake? Time taken to go back to sleep -  |
| Nightmares / vivid dreams |  |  |
| Mental Clarity / memory |  |  |
| Bowel function overall (consiptation / loose / diarrheoa / lots of wind / mucus / constipated / etc) |  |  |
| Skin  |  |  |
| Night sweats |  |  |
| Bloating |  |  |
| Wind / flatulence.  |  | Is *it Odorous?*  |
| Sense of Wellbeing |  |  |
| Was your diet |  |  |
| Weight  |  |  |
| Irritability |  |  |
| Moodiness |  |  |
| Teariness / Emotionality |  |  |
| Frustration / Irritability |  |  |
| Sugar cravings  |  |  |
| Libido |  |  |
| Migraine |  |  |
| Tinnitis / ringing in the ears |  |  |
| Cardiovasular health |  |  |
| What exercise are you currently doing? |  |
| Any other health / emotional / lifestyle issues? |  |  |

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| **WOMEN :-** |  |  |
| Menstrual pain  |  | *1ST day of last period – date :*  |
| Breast Tenderness |  |  |
| Fluid retention |  |  |
| Spotting |  |  |
| Flushing / sweating (day / night) |  |  |
| How long was your last cycle(first day of period to day before flow of next period) |  |  |

BODY PAIN / DISCOMFORT : Please rate where **1 = low / 10 = high.**

|  |  |  |
| --- | --- | --- |
| Muscle tension / hardness / knots |  |  |
| Body pain |  |  |
| Headaches* intensity
 |  |  |
| Neck & Upper Shoulders |  |  |
| Middle Back |  |  |
| Lower Back |  |  |
| Legs |  |  |
| Arms & shoulders |  |  |
| Joints |  |  |
| Legs & feet |  |  |

|  |  |
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| **Medical Update** – history, tests, diagnostics or findings.  |  |
| Do you see any other health care professionals?  |  |
| Describe your health history. Include hospitalisations, surgeries, diagnostics, health issues, life crises, symptoms etc. |  |
| What surgeries / medical interventions have you had? Do you have a pacemaker? |  |
| Do you have a mental illness or similar diagnosis or experience? |  |
| Do you have a contagious health issue or infection? |  |
| How many Neurofen, Panodol, Antibiotics or other over the counter medicines have you used in the last month? What were they for? |  |
| What medications are you taking at present, and what have you used in the past?  |  |
| What Supplemnets do you take? |  |

Are you of sound mind and health?

|  |  |
| --- | --- |
| Is there anything else we need to know? |  |

**Please read, sign and return before your session :**

**Session Information** - It is important to understand that this session is not intended to diagnose or treat any medical, mental or physical condition. This session is simply an infusion of the Reconnective Healing energies for your body to utilise in its innate wisdom. We offer no promises or claims about what will happen during or after your session. We do not intend or promise any medically therapeutic results, as we cannot gauge how your body will use this energy. Consider this session to be similar to a meditation that you are engaging in during the time you are on the table.

Most people feel the sensations of tingling, warmth, pressure, twitching and more, some people don’t feel anything other than a lovely feeling of relaxation. To understand this energy, it is important that you have watched the videos located on the website under Reconnective Healing. By signing this form you are acknowledging that you have watched these programmes and are responsible for asking any questions before your session.

It is best to have no expectations, no judgements, no preconceived ideas and no agenda when you receive this session. If you are holding on to any of these you experience better results the more you let go of preconceived judgements and expectations. If you can observe yourself observing, noticing when you notice something, noticing when you notice nothing, then noticing when you notice something again. This energy has its own intelligence and it will go where it is needed most. Open your heart and open your mind, and let go of everything else.

**DISCLAIMER** – All information offered is given as information only, not as diagnostically predictive or legally binding information, just the personal opinion of the sayer.  No-one can heal the body or influence your experience other than you. All healing is self healing and you are responsible for your own healing, and your own decisions at all times. This work and anything discussed is no substitute for working with your doctor or other practitioners.

Date : Name : Sign :