Reconnective Healing / Emotional Healing Questionnaire

How did you hear about us?

Name :	**Phone** :	**Email** :
Address :	Emergency Contact & their relationsip to you:	
DOB : Age : Current Weight : Ideal Weight Height:	What work do you do? What are your Hobbies	Who do you live with? Are you Married / Single / Partnered / Divorced / Widowed Partner's name & age: Children:

Do you currently have a contagious condition / cough / respiratory illness / blood-borne virus?	**Do you have a mental illness / issue?** (eg OCD, bipolar, schizophrenia, depression, anxiety, suicidal)	**Do you have any Addictions** (eg: Sugar / drugs / alcohol / smoking / sex / gambling / gaming)

What brings you in for a session today? **What are you wanting help with?**

Current Medications, dose, when started (year), and what they are for. Include medications you take occasionally, and how often you take them in a month.

Current Supplements, brand, how long you have taken and what they are for?

Briefly, what is the story of your current issue/s? What is going on in your life right now? What recurring thoughts are occupying your mind most at present?

In order of priority, what are the top three things you want to achieve?

1.

2.

3.

What do you think are your present obstacles to health and happiness?

Do you have any diagnosed Medical Conditions?

Do you have any health concerns?

What Medications &/Recreatioal drugs do you take regularly or occasionally?

Are you under medical care?
Doctor / clinic details:
When was your last visit and what was it for?

What Supplements (& brand) do you take regularly or occasionally and what is it for?

What is going on in your life right now?

Do you have any pain?	What are your spiritual/religious beliefs?

Is there anything else we may need to know?

Current Health Overview:

10=high 5 = moderate 1 = low 0=nil

Please rate your:	*0-10*	Comments
Energy levels overall		Indicate if varies between morning, afternoon and evening
Stress levels overall		
Level of Anxiety		
Depression		
Irritability / Frustration?		
Teariness / Sensitivity?		
Low mood		
Memory recall		
Rate your overall sense of Wellbeing		
Rate your **Weight**?		
Sugar cravings		High / moderate / low / non-existant
Rate your Skin		
Histamine – itching, rashes, hives		
Sinus problems (blocked, congested, Post nasal drip)		
Ears – Ringing, itching, blocked, infection		
Overall Digestive Function?		
Bloating / distenston		Indicate frequency : a few times in a day / daily / every other day / weekly / other
Reflux / gastric burning sensation		
Gut pain / nausea		
Rate your Bowel function		Indicate : well formed & easy to pass / loose / diarrhoea / lots of wind / mucus / constipated / urgent / other:
How often do you have a bowel motion...		Frequency : a few times in a day / daily / every other day / weekly / other
Wind / flatulence. Is *it Odorous?*		
Do you have any Haemorrhoids or blood on wiping?		
SLEEP - Rate your sleep quality overall		(10=go to sleep easily, sleep through the night and wake well rested)
Average hours of sleep		
How often do you wake at night?		What time/s do you wake? Time taken to go back to sleep -
Overnight trips to the loo (number)		

Do you have any body pain or discomfort? Please rate where **1 = low / 10 = high.**

Muscle tension / hardness / knots		
Body pain		
Headaches – frequency, intensity etc.		
Neck & Upper Shoulders		
Middle Back		
Lower Back		
Legs		
Arms & shoulders		
Joints		
Legs		
Feet		
What exercise are you doing & how much? Rate the intensity MILD/MODERATE/HIGH		

Women's Health (As Appropriate)

HORMONES – overall sense of Hormone Balance?		Notes:
Any night sweats?		
Libido overall?		High / moderate / low / non-existant

Menstrual pain		
Breast Tenderness		
Premenstrual Tension / Mood changes b4 pd		
How long was your last cycle (first day of period to day before flow of next period)		Cycle length (days) : 21 / 28 / 30 / 40+ 1st day of last period – date :
Menopause / Perimenopause?		Year it started :

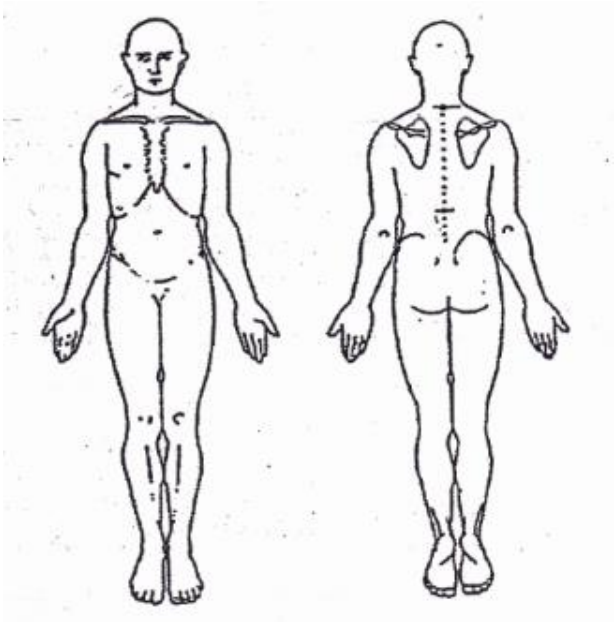
Do you lose bladder control when you sneeze?	
When was your last pap smear & what was the result?	
How many mamograms have you had?	Bone Denisty Tests?
In Pregnancy did you have any issues? High blood pressure? Diabetes?	

Men's Health (As appropriate)

Has the strength of the urine stream changed?:		Has your ability to develop or maintain an erection changed?	
Are you concerned about your prostate?		Are you concerned?	

How is your body feeling?

Mark any areas of discomfort or issue, and rate out of 10, where 10 is strong / severe.



Current & Past Medical:

Are you currently under medical care? Doctor / clinic details: When was your last visit and what was it for?	
Are you seeing any other practitioners? Who and what for?	
Outline your Medical History : What have you been diagnosed with in your life – include year/s and treatment?	**What Medications have you used in the past**? (Include when, how long for and what for? Also include recreational drugs.)

Hosptialisations / Surgery –

What organs do you no longer have (tonsils, appendix, gallbladder …)?	Do you have a pacemaker?
Have you had a transplant?	Do you have any implants or prosthetics?
How many general anaesthetics have you had?	How many : Xrays MRIs CAT scans What for?

Health History. Please indicate which of the following apply to you:

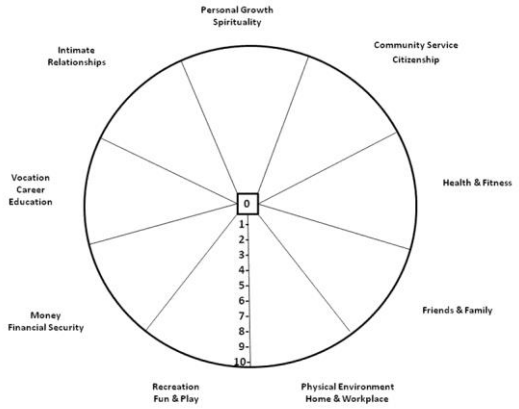
			Parasites		Memory issues		Abnormal Pap Smear
	Hayfever		History of gastro / Bali belly		Dizziness		Anaemia
	Hives / Urticaria		Coeliac Disease		Tinnitis / Ringing in the ears		Ovarian Problems
	Sinus issues		Irritable Bowel		Circulation Problems		Endometriosis
	Herpes		Coronary Artery Disease		Cold hands / feet		
	Cold sores		Diverticular Disease		Parkinson's Disease		Numbness
	Glandular Fever (EBV/CMV)		Reflux		Dementia/Alzheimer's		Ovarian cysts
	Molluscum		Hiatal Hernia		Paralysis / parasthesia		Fibroids
	Chicken pox		Stomach Ulcers		Abnormal Heart Valve/s		Thrush
	Measles		Helicobacter		High Blood Pressure		
	Bronchitis		Gluten sensitivity		Tingling		Anxiety
	Pneumonia		Dairy Sensitivity		Migraines		Panic attacks
	Asthma		Colon or Rectal Polyps		Headaches		Depression
	Shortness of breath		Gall Stones		Eczema		OCD
	Chronic cough		Skin Tags		Psoriasis		Autism
	Post Nasal Drip		Diabetes		High Cholesterol Level		Aspergers
	COPD/Chronic Lung Dx		Cataracts		Cartoid artery obstruction		ADD / ADHD
	Tuberculosis		Osteoarthritis		Blood Clots/DVT		Schizophrenia
	Lung problems		Reumatoid arthritis		Stroke		Seizures / Epilepsy
	Sleep Apnoea		Broken Bone/s		Hearing Loss		Pre-eclampsia
	Burning tongue		Osteopenia		Stroke		Post Natal Depression
	Burning skin		Osteoporosis		Irregular Heart Beats		Gestational Diabetes
	Raynauds		Fatty Liver		Atrial Fibrillation		Cesarean
	Wandering joint pain		Cirrhosis		Heart Failure		Stillbirth
	Auto-immune disease		Hepatitis		IVF treatment		
	AIDS		Hemochromatiosis		Blighted Ovum		
	PANS / PANDAS		Glaucoma		Miscarriage/s		
	Cancer		Macular Degeneration		Grief		
	Mouldy environment		Prostate Issues		Smoking		Trauma
	Asbestos contact		Kidney Disease		Parents smoked		Narcissistic Parent / sibling
	Mercury amalgums		Gout		Farming history		
	Strep Thoat		Scars - internal				
	Golden staph		Scars - external				
	Shingles						

VACCINES – what year/s and how many doses have you had of:

Flu injections	Pneumonia	Tetanus	Hepatitis	Yellow fever
MMR	Chicken Pox	Whooping cough	Tuberculosis (TB) – this would have left a scar on your shoulder.	
HPV (Giardasil - Cervical Cancer vaccine)			Other:	

Life Balance Assessment

Rate	WHEEL OF LIFE	

	Rate each area out of 10, where 10 is perfectly satisified.	
	Personal Growth & Spirituality	
	Community, Service, Citizenship - Sharing in a community sense.	
	Health	
	Fitness	
	Friends	
	Family	
	Physical Environment - Workplace / School	
	Physical Environment – Home / Living zone	
	Recreation, Fun, Play	
	Money, Financial Security	
	Vocation, career, education	
	Intimate relationships	
	Sense of Self, confidence, personal respect	
	Other area/s of importance to you :	

How do you think this work will make you feel in your body / life / experience?

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 helps to have watched some of the videos put out on Reconnective Healing.

It is best to have no expectations, no judgements, no preconceived ideas and no agenda when you receive this session. Open your heart and open your mind, be in a state of reception, and let go of everything else. Let go of your body as well. Sometimes the body moves during the sesion, just allow it. Sometimes your tummy can make noises as the energy begins to flow, just allow it. Notice what you notice, yet don't hold on to anything.

If you need anything during your session, please ask. This is your session and it is important that you are comfortable. If lying down isn't comfortable we can do the session sitting up, lying face up, or lying face down, whichever you prefer.

DISCLAIMER - Any information, data, documents, guidelines, images or general material is for general information only, and is not intended to be prescriptive or diagnostic, simply informative. I understand the above and will remain in full responsibility for myself, my actions and decisions.

All information provided is true and correct.

Date : Name : Sign :