Bio-Energy Healing
Client Record Form

Michael D'Alton's
School of Bio-Energy Healing

Date:

Name:

Address:

E-mail:

Phone Number: Cell:

Date of Birth:

Occupation:

Relationship Status: Dependents:

Past Health History (including major life events):

Present Health (including current medication and/or medical or alternative treatments):

Reason for having Bio-Energy Healing:

Michael D'Alton's
School of Bio-Energy Healing

Bio-Energy Healing
Initial Evaluation Form

In order to assess the benefits received from the therapy, please take a few moments to complete this form **before** your initial session.

Name: _____ Date: _____

Therapist: _____ Treatment No: _____1_____

Main Concern _____

Please circle the number that best indicates the average level you are experiencing.

PAIN

pain free 0 1 2 3 4 5 6 7 8 9 10 worst possible

STRESS/ANXIETY

none 0 1 2 3 4 5 6 7 8 9 10 worst imaginable

DEPRESSION

none 0 1 2 3 4 5 6 7 8 9 10 extreme hopelessness

ENERGY LEVEL

very energetic 10 9 8 7 6 5 4 3 2 1 0 very low energy

SLEEPING

great sleeping 10 9 8 7 6 5 4 3 2 1 0 not sleeping at all

OTHER: _____

best possible 10 9 8 7 6 5 4 3 2 1 0 worst possible