*Emotional Freedom Techniques*
for Horses & Riders
www.eft4horsesandriders.com

**Client Medical and Release Form**

Client Name: _____

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Home Ph: _____ Work Ph: _____ Cell: _____

Email: _____

Age: _____ Present Occupation: _____

Who may I thank for referring you to me? _____

Are you using any other therapies at this time for your health? Yes ___ No ___
If yes, please describe:

_____

_____

_____

Are you presently under the care of a chiropractor? Yes ___ No ___
Have you ever had craniosacral therapy? Yes ___ No ___
Are you presently under the care of a naturopath? Yes ___ No ___

Please list any problem(s) that you would like to address and how long they have been present.
Feel free to use the back of this page if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Client Medical & Release Form**
Page 2

Please list any prescription drugs you are presently taking and which health challenge they are currently addressing.

Have you had any surgery? Yes ___ No ___
If yes, please describe below (include any dental surgery):

| Surgery | Date |
|---|---|
| | |
| | |
| | |

If you have had any lab tests, x-rays or other diagnostic tests done in the past year, please list them below with details:

Have you ever had a bad fall, been in a car accident or had any other serious accident: Yes ___ No ___

If yes, please describe and provide date(s) of the injury:

**Client Medical & Release Form**
Page 3

| | | |
|---|---|---|
| Are you diabetic? | Yes ___ | No ___ |
| Do you have problems sleeping? | Yes ___ | No ___ |
| Do you have high blood pressure? | Yes ___ | No ___ |
| Have you ever had heart problems? | Yes ___ | No ___ |
| Have allergy symptoms been a problem? | Yes ___ | No ___ |
| Have you been bothered by skin rashes, itching or hives? | Yes ___ | No ___ |
| Do you get short of breath easily? | Yes ___ | No ___ |
| Have you had problems with asthma? | Yes ___ | No ___ |
| Do you have digestive problems? | Yes ___ | No ___ |
| Have you ever lost consciousness? | Yes ___ | No ___ |
| Do you have problems with numbness? | Yes ___ | No ___ |
| Do you have problems with joint pain? | Yes ___ | No ___ |
| Have you ever had a seizure? | Yes ___ | No ___ |
| Is there a history of seizures in your family? | Yes ___ | No ___ |
| Do you suffer from anxiety? | Yes ___ | No ___ |
| Do you suffer from panic attacks? | Yes ___ | No ___ |
| Do you or have you ever suffered from depression? | Yes ___ | No ___ |
| Have you ever received a psychiatric diagnosis? | Yes ___ | No ___ |

If yes, please provide details:

Is there anything else you would like to tell me about your current state of health?

My signature promises full payment for services as well as full disclosure of any and all health related illnesses and history as well as my full understanding that Energy Therapy is not a replacement for medical care from my healthcare provider.

Signature: _____ Date: _____