

**CLIENT INTAKE FORM
(CONFIDENTIAL-FOR PRACTITIONER'S USE ONLY)**

Name _____ email _____ Mailing list Yes/No? _____ Date _____
 Address _____ Date of Birth _____
 City _____ Postal Code _____ Height _____ Weight _____
 Phone Home _____ Work _____ Occupation _____
 Emergency Contact (name & phone) _____
 Relationship Status _____ # Children _____ Ages _____ Referred by _____
 Physician (name & phone) _____
 Therapist (name & phone) _____
 Reason for Visit (add details on back if necessary) _____ Date of Onset _____
 Current/Previous Treatment (for reason for visit) _____
 Current Medications _____ Supplements _____
 Current Complementary Therapies _____
 Eating Habits/Diet _____
 Amount Daily Intake: Water _____ Caffeine _____ Alcohol _____ Cigarette/Tobacco _____
 Exercise routine _____
 Vision _____ Wear glasses/contacts _____ Smell _____ Hearing _____ Taste _____

Please mark the following areas of disease or symptoms as "C" - current "P" - past, "O" – occasional and "CH" - chronic. Explain if necessary.

EMOTIONAL/PSYCHOLOGICAL	NEUROLOGICAL (type)	RESPIRATORY	REPRODUCTIVE
Depression	Epilepsy	Bronchitis	Sexually Trans. Disease (type)
Eating disorder	Dizziness	Pneumonia/Pleurisy	
Mood swings	Insomnia	Tuberculosis	
Substance abuse	Migraines	DIGESTION	Endometriosis
AUTO-IMMUNE (type)	MUSCULO-SKELETAL	Constipation (chronic)	Pregnancies (# & C if current)
AIDS/HIV	Arthritis	Diabetes	Miscarriages (#)
Allergies	Rheumatism	Diarrhoea (chronic)	Abortion (#)
Cancer (type)	Back Pain	Gastritis	MAJOR ILLNESSES
Fatigue	Carpal Tunnel	Hepatitis	Chicken Pox
Fever (chronic)	Gout	Hypoglycaemia	Measles
Fibromyalgia	Skin Disorder (type)	Jaundice	German Measles
Fungal Infections (type)	EAR/NOSE/THROAT	Liver Disorder	Mumps
Herpes (type)	Earaches (chronic)	Ulcers	Whooping Cough
Lymes Disease	Headaches	Flatulence	Rheumatic Fever
Mononucleosis	Jaw Pain	Pancreas	Scarlet Fever
ENDOCRINE	CARDIO-VASCULAR	URINARY	OTHERS
Adrenal Insufficiency	Angina	Bladder Infection	
Pituitary Dysfunction	Heart Attack	Kidney Stones	
Hyperthyroid	Heart Failure		
Hypothyroid	Hypertension		
	Stroke		

Please list any injuries past or present:

Please list any surgeries past or future:

Please list any traumatic, or life threatening events that occurred in your life, and when they happened:
(Ex. Separation, divorce, deaths, depressions or other significant event)

What do you hope for and what are your expectations from this healing today and long-term:

What is your connection with spirituality (religious background, development, current practice)

Brothers/sisters _____ Rank in family _____

Relationship with mother _____

As a child _____

Present _____

Relationship with Father _____

As a child _____

Present _____

General (further details on reason for visit or anything else you want to share or want me to know)

Consent Form for Treatment

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

As a healer, I do not medically diagnose or prescribe treatment. My approach is holistic, focusing on you as a complex, dynamic, unique being – body, mind, and spirit – and I serve as a facilitator in your process of healing.

We may explore areas that influence your state of well-being, such as your health history, life stressors, your belief systems and attitudes, your family and childhood history, diet, exercise, and how you are in relationship. Your sharing is always kept confidential. I do, however, discuss clients (without mentioning their names) with my professional supervisor or professional peers for the purpose of my continuing professional development.

The hands-on healing techniques balance, clear, and charge your energy field and system, remove energetic blocks that lead to disease or dis-ease, and enhance your body's natural healing potential. At times I will touch your body, and at other times I may work with your energy field off your body. I may also use sound to free up blocks. If at any time during the session you are uncomfortable, it is your responsibility to inform me. Self-care is an extremely important part of your healing process.

Due to the nature of this work, I recommend that you refrain from using alcoholic beverages for 24 hours following your session. I am most happy to answer questions regarding my services, and I also encourage you to express any concerns that you may have.

Roland Berard

I have read and understand the above information provided by Roland Berard. I further understand that his services are not to be interpreted as medical examination, diagnosis, or a substitute for medical treatment, and that nothing said or done during the course of the session given should be interpreted as such. Any questions I currently have, have been answered to my satisfaction.

The client confirms that s/he has presented themselves in their own name, in good faith and for no other reason than obtaining a natural therapy treatment.

Signature _____

Date _____

Policies for Cancellation, Lateness and Returned Checks

Cancellation of an appointment

Please advise a minimum of 24 hours (preferably 48 hours) in advance of a change or cancellation for an appointment; otherwise the **full payment** of the session will be due and must be paid prior to continuing treatments.

Lateness

If you are late for an appointment, we will use the time that is remaining in your scheduled time slot; **full payment** will still be due.

The duration of the initial session is approximately one hour and one quarter (1-¼ hours) and the subsequent sessions are 50 minutes.

If you feel you need more time in a session, it is possible to schedule a longer session ahead of time; the fee will be adjusted accordingly.

Checks returned by the bank

There is a \$15 charge for processing checks returned by the bank.

INFORMATION RELATIVE TO THE LAW ON PROTECTION OF PERSONAL INFORMATION IN THE PRIVATE SECTOR (BILL 68)

You have given us information relevant to your personal file. Following the enactment of Bill 68, unless otherwise indicated by you, we consider that we have your consent that we indicate in our files any information that you may have given us, verbal or written. Also, unless we have had official notification from you by registered mail, we consider that your consent is valid for a period of five (5) years.

CONSENT

I freely agree that

ROLAND BERARD

may keep a record on file of any and all information that I have given him, whether written, oral or otherwise, from now on.

I have also read and understood and I agree to respect the policies for Cancellation, Lateness and Returned Checks.

Signature : _____

Date : _____