

Mountain Light Healing, LLC

Integrative Energy-Medicine Practices ▪ Compassionate Whole-Health Solutions

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CONFIDENTIAL GENERAL AND MEDICAL INFORMATION

Client Name: _____ DOB: _____

Date(s): _____

YES	NO	QUESTION
		Do you frequently suffer from stress?
		If Yes on stress, can you identify the primary source(s) of your stress?
		Do you experience frequent headaches?
		Do you suffer from migraines?
		Are you wearing prescription eye glasses or contact lenses?
		Do have any blood sugar issues?
		Are you diabetic?
		Do you have high or low blood pressure?
		Do you have seizures?
		Do you have an autoimmune disorder?
		Do you have thyroid imbalances? Hypothyroidism? Hyperthyroidism?
		Do you have cardiac or circulatory problems?
		Have you had surgery in the recent past?
		Do you have implanted medical devices or metal parts, stents, or organ transplants?
		Have you had any broken bones in the past two years?

YES	NO	QUESTION
		Do you have any tension or soreness in any specific area of your body? If yes, where?
		Do you suffer from back pain? If yes, where?
		Do you have numbness or stabbing pain anywhere in your body? If yes, where?
		Have you been diagnosed with cancer?
		Are you receiving cancer treatments?
		If female, are you pregnant or lactating?
		Have you been diagnosed with any mental disorders?
		Do you have any other medical condition I should be aware of?
		Are you very sensitive to touch or pressure in any specific areas?
		Are you taking prescription medications? Hormones?
		Are you experiencing any side effects from medications you are taking?
		Are you taking supplements? For what condition(s)?

Comments: _____